DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5Z1K

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00149

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245223**

2. STATE VENDOR OR MEDICAID NO. (L2) **955270700**

3. NAME AND ADDRESS OF FACILITY
(L3) **RED WING HEALTH CENTER**
(L4) **1412 WEST FOURTH STREET**
(L5) **RED WING, MN** (L6) **55066**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **10/25/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **130** (L18)

13.Total Certified Beds **130** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	130			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Sandra Tatro, HFE NE II 10/18/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/25/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
11/01/1978
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245223

January 25, 2018

Mr. Dennis Decosta, Administrator
Red Wing Health Center
1412 West Fourth Street
Red Wing, MN 55066

Dear Mr. Decosta:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective October 25, 2017 the above facility is certified for:

130 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 130 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered

January 25, 2018

Mr. Dennis Decosta, Administrator
Red Wing Health Center
1412 West Fourth Street
Red Wing, MN 55066

RE: Project Number S5223027

Dear Mr. Decosta:

On October 3, 2017 and October 17, 2017, we informed you that the following enforcement remedies were being imposed:

• State Monitoring effective October 22, 2017. (42 CFR 488.422)

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective October 28, 2017. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on July 28, 2017, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on September 28, 2017. The most serious deficiencies at the time of the revisit were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On October 25, 2017, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on September 28, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 25, 2017. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on September 28, 2017, as of October 25, 2017. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective October 25, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letters of October 3, 2017 and October 17, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective October 28, 2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective October 28, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective October 28, 2017, is to be rescinded.

In our letter of October 3, 2017, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 28, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 25, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT
FOR NURSING HOMES

December 19, 2017

Dennis Decosta, Administrator
Red Wing Health Center
1412 West Fourth Street
Red Wing, MN 55066

RE: Project Number S5223027

Dear Mr. Decosta:

On October 25, 2017, a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility. That Notice, which was received by the facility on October 25, 2017, imposed a daily fine in the amount of $300.00.

On October 25, 2017, an acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on October 25, 2017 and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is $300.00. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the reinspection, totaling $208.80, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of $508.80 within 15 days of the receipt of this notice. That check should be forwarded to the Department of Health, Health Regulation Division, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit

Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5Z1K

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00149

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245223**

2. STATE VENDOR OR MEDICAID NO. (L2) **955270700**

3. NAME AND ADDRESS OF FACILITY
(L3) **RED WING HEALTH CENTER**
(L4) **1412 WEST FOURTH STREET**
(L5) **RED WING, MN** (L6) **55066**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **9/28/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **130** (L18)

13.Total Certified Beds **130** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	130			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Sandra Tatro, HFE NE II 10/18/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/29/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
11/01/1978
(L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Electronically delivered

October 17, 2017

Mr. Dennis Decosta, Administrator
Red Wing Health Center
1412 West Fourth Street
Red Wing, MN 55066

RE: Project Number S5223027

Dear Mr. Decosta:

On August 11, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 28, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 28, 2017, the Minnesota Department of Health and on September 11, 2017, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 28, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 11, 2017. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on July 28, 2017. The deficiencies not corrected are as follows:

F431 -- S/S: E -- 483.45(b)(2)(3)(g)(h) -- Drug Records, Label/Store Drugs & Biologicals
F441 -- S/S: D -- 483.80(a)(1)(2)(4)(e)(f) -- Infection Control, Prevent Spread, Linens

The most serious deficiencies in your facility were found to be to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby corrections are required

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective October 22, 2017. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last

day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective October 28, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective October 28, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 28, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Red Wing Health Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective October 28, 2017. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that

the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedy be imposed:

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 28, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	R 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED WING HEALTH CENTER	**1412 WEST FOURTH STREET RED WING, MN 55066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on September 27, and 28, 2017. The certification tags that were corrected can be found on the CMS2567B. Also there are two tags that were not found corrected at the time of onsite PCR which are located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 431} SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed	{F 431}		10/20/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/17/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	R 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED WING HEALTH CENTER	**1412 WEST FOURTH STREET RED WING, MN 55066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 431}	Continued From page 1 pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to dispose of expired and discontinued medications in 2 of 5 medication	{F 431}	F 431 Storage of Medication Immediate corrective action: The Humalog Insulin and Air Life	

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{F 431}	Continued From page 2 carts affecting residents (R92,R70, R94) and facility stock supply. Findings include: On 9/27/17, at 9:15 a.m., a medication storage cart on 3 west was checked with licensed practical nurse (LPN)-D. An unsealed bottle of Humalog insulin, labeled for administration to R92, was observed to have a manufacturer's expiration date of 8/25/17. LPN-D stated that R92 had received this medication from this bottle yesterday. LPN-D reviewed the resident's Medication Adminstation Record (MAR) and stated this medication had been given in varying, small doses up to three times per day through-out the prior week, as ordered by R92's physician even though it had expired on 8/25/17. On 9/27/17, at 9:18 a.m. 2 west (2W) medication storage cart was checked with licensed practical nurse (LPN)-A. Medication bottles and cards were checked for expiration dates and dates bottles were opened if needed. LPN-A stated that she checks expiration dates when she dispenses medications and removes any expired medications from the cart. There were two bottles of Probiotic 10 labeled for R70. One of the bottles had a label to keep it refrigerated. LPN-A stated she had checked and the Probiotic had been discontinued for R70 and said she did not know why the medication was still on the cart. The second medication cart on 2W was checked with LPN-B and there was a Humalog Flex Pen that did not have a pharmacy label on it. The date the insulin pen indicated it had been opened 6/11/17. In addition, there was a piece of white tape across the insulin pen with the first name and last initial of R94 handwritten on it, and there was a	{F 431}	Modudose identified was discarded. Action as it applies to others: Medication will be checked as part of the medication administration policy and procedure to assure when medications are opened they are labeled; to assure dates are current and any outdated medication will be destroyed per medication destruction policy. All licensed nurses were in-serviced on the process of dating medications when opened and checking medication carts/rooms/refrigerators for expired medications each shift during their medication passes as part of their daily medication pass routine. Date of completion: __10/20/2017__ Recurrence will be prevented by: All medication carts/rooms/refrigerators will be audited 1x weekly for dating medications when opened, proper labeling, and for expired meds. This audit will continue x60 days and results shared with the facility QAPI monthly for input on the need to increase, decrease, or discontinue the audits. The correction will be monitored by: DON/Designee	

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{F 431}	Continued From page 3 box with 11 individual dose vials containing Air Life Modudose 0.9% sodium chloride solution (a saline solution to help improving breathing) with an expiration date of July 2015. LPN-B stated that the vials were used for mixing a nebulizer (a breathing treatment that uses a machine to change medication solution into a mist for inhaling by the resident). LPN-B stated she did not know if the solution had been used for any resident's nebulizer treatment. When asked about the insulin pen LPN-B stated that she did not think R94 was currently receiving that form of insulin. LPN-A was asked how she knew how long to keep an open container insulin in use LPN-A stated there was supposed to be a laminated sheet on the medication cart with the number of days it was acceptable to keep eye drops, nasal sprays, and insulin after opened. However LPN-A acknowledged she had not seen one of those sheets yet. The medication administration record (MAR) from May 2017, through September 2017, for R94 were reviewed. It was noted Humalog insulin had been administered to R94 once on 8/16/17, 35 days after the expiration date of 7/12/17. Medication Storage Policy number NS0163, last revised on January 2017 directs "No discontinued, outdate or deteriorated medications/solutions are available for use in the facility. All such medications/solutions are destroyed." During interview on 9/28/17, at 8:30 a.m. the Director of Nursing stated her expectation was for no residents to receive expired medications, and that she expected all expired medications to be destroyed.	{F 431}		

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{F 441} SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS	{F 441}		10/20/17

(a) Infection prevention and control program.

The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism

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{F 441}	Continued From page 5 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper hand hygiene and gloving were performed to prevent the spread of infection for 2 of 4 residents (R70, R84) observed for perineal care and wound treatment. Findings include: R70's admission record dated 9/29/17, indicated current diagnoses of quadriplegia, urinary tract infections and history of methicillin resistant	{F 441}	F 441 Infection Control Immediate corrective action: NAR A, B, and C were re-educated and handwashing/glove use policy and competencies completed on 10/18/17. LPN A was re-educated on handwashing policy and competency was completed on 9/29/17. Action as it applies to others: The Policies and Procedures for handwashing and glove use change	

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{F 441}	Continued From page 6 staphylococcus aureus infection. Weekly wound documentation for R70 dated 9/4/17, indicated R70 had a left lower leg (rear) pressure wound, that was length 5.5 centimeter (cm) by width 4 cm unstageable, clean apply Santyl cover with Optifoam, change q (every) day and prn (as needed). On 9/28/17, at 9:49 a.m., during R70's morning cares, nursing assistant (NA)-B knocked on the door and entered the room. NA-B observed to wash hands then donned gloves and proceeded to wash R70's face with wet wash cloth from a basin with water then dried R70's face with dry towel. NA-C knocked and entered R70's room, washed hands and donned gloves. NA-B continued cares and washed R70's bilateral under arms with wet wash cloth then dried under arms with dry towel. NA-C then put deodorant on R70's under arms. NA- B and NA-C donned R70's t-shirt. With R70's head of bed lowered flat, NA-B took R70's incontinence brief off and provided peri care. NA-B with the same soiled gloves placed hands on R70's body to turn resident on right side. While R70 was laying on right side, NA-C wiped R70's buttock's area with disposable wipes. NA-C confirmed R70 had a bowel movement then R70's incontinence brief was tucked under. R70 was rolled on back and NA-C proceeded to hold on to R70 to put on clean incontinence brief. NA-B and NA-C both removed soiled gloves and did not immediately wash their hands. NA-B and NA-C continued with R70's, shorts were put on along with soft booties on both feet. Then the mechanical lift sling was positioned under R70's body. NA-B dumped water out of basin. NA-C put dirty lines in clear plastic bag. NA-B along with NA-C then washed hands.	{F 441}	remain current. All nursing staff have been educated for handwashing and glove use. Date of completion:10/20/2017. Recurrence will be prevented by: Visual audits of handwashing practices when indicated, to include proper barriers as well as hand washing and glove changing will be conducted 2x weekly x30 days on various Units. Results will be shared with and evaluated by the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: DON/Designee	

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{F 441}	Continued From page 7	{F 441}		

During an interview on 9/28/17 at 10:10 a.m., NA-C stated, "I should have have changed gloves after cleaning his bottom, thought I washed hands after putting his shorts on." When asked what would be the expectations for hand hygiene NA-C stated that should wash hands anything after peri care and when you change gloves.

During an interview on 9/28/17 at 10:39 a.m., when asked NA-B about hand hygiene expectations she stated when you walk into the room and after anything dirty like pericare. NA-B stated when asked if she washed hands after peri care with R70 she stated she did not do it right after peri care.

During an interview with Director of Nursing (DON) on 9/28/17 at 2:17 p.m., DON's expectations for hand hygiene would be to follow policy and procedure, staff should use handsanitizer or handwashing when removing gloves. When gloves or hands are soiled staff should be washing their hands.

During an observation of a dressing change on 9/28/17 at 11:02 a.m., licensed practical nurse (LPN)-A, came in R70's room and washed hands then donned gloves. LPN-A removed dressing on R70's left calf, dressing had small amount of half circle brown drainage, LPN-A folded dressing, then set dressing on bare mattress, placed normal saline on gauze with same gloves on, then wiped wound with wet gauze, placed gauze on bare mattress with dressing, with the same gloves on grabbed another gauze patted wound dry, put dry gauze on bare mattress, with same gloves on LPN-A picked up tube of Santyl put it over eschar of wound, stated wound had more

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{F 441}	Continued From page 8	{F 441}		

granulation tissue and still getting eschar off around wound. LPN-A put on new dressing on left calf then dated dressing. LPN-A then removed gloves and washed hands and donned new gloves. LPN-A observed to take dressing off suprapubic site. At 11:08 a.m., NA-C knocked and came into R70's room, washed hands then donned gloves. LPN-A cleaned the catheter connection with alcohol wipe. NA-C then held catheter line as LPN-A flushed the line with a clear liquid towards R70. LPN-A put normal saline on gauze, wiped suprapubic site dry with gauze and placed a split gauze over suprapubic site. LPN-A put tape on the split gauze and dated dressing. LPN-A took gloves off. NA-C washed her hands and left the room. LPN-A adjusted resident position and washed hands and left the room.

During an interview on 9/28/17 at 1:34 p.m., when asked LPN-A if she changed gloves after old dressing was removed during the dressing change, LPN-A verified she did not change her gloves.

R84 had been observed on 9/27/17, at 1:52 p.m. after nursing assistant (NA)-A was observed washing his hands prior to going into R84's room. R84 stated he was "soaked" through to the sheet. NA-A went out of room and came back with clean linens for the bed. Clean linens were placed on the bedside table. NA-A gathered wipes and a clean incontinence brief, put on a pair of gloves and removed the top sheet from the bed and placed it on the floor at the foot of the bed. NA-A proceeded to loosen the bottom sheet from the wall side of the bed and tucked under R84's shoulder. NA-A then opened up the incontinence brief R84 was wearing and began cleaning R84's front peri area. NA-A had R84 roll towards the

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{F 441}	Continued From page 9	{F 441}		

wall. NA-A then removed the incontinence brief R84 was wearing, wiped the rectal area with several wipes, and put a clean brief on R84. NA-A then removed the bottom sheet and the draw sheet from the bed and placed them on the floor at the foot of the bed. Without changing gloves, NA-A took the clean bottom sheet and clean draw sheet and put them under R84. Then NA-A had R84 roll onto his back again. NA-A finished putting the bottom sheet and draw sheet into place on the bed. NA-A asked R84 if he wanted a top sheet. R84 indicated that he did so NA-A put a clean top sheet over R84. NA-A then picked up the remote control for the bed and lowered bed down to lowest level. NA-A then removed his gloves and went into the bathroom and washed his hands.

During an interview with Director of Nursing (DON) on 9/28/17 at 2:17 p.m., DON's expectations for hand hygiene during dressing change, was hands should be washed when gloves are donned and after soiled dressing was removed.

The facility's hand washing policy dated October 2014, "Employees must wash their hands for at least 20 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: b. When hands are visibly soiled (hand washing with soap and water); h. Before and after assisting a resident with personal care (e.g., oral care, bathing); k. Before and after changing a dressing; f. After handling soiled or used linens, dressings, bedpans, catheters and urinals."

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on XXXXXXX.

October 17, 2017

Mr. Dennis Decosta, Administrator
Red Wing Health Center
1412 West Fourth Street
Red Wing, MN 55066

Re: Project Number S5223027

Dear Mr. Decosta:

On September 28, 2017, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 28, 2017 with orders received by you electronically on August 11, 2017.

State licensing orders issued pursuant to the last survey completed on July 28, 2017, found not corrected at the time of this September 28, 2017 revisit and subject to penalty assessment are as follows:

21375 -- MN Rule 4658.0800 Subp. 1 -- Infection Control; Program - $300.00

The details of the violations noted at the time of this revisit completed on September 28, 2017 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of $300.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at the address below or to, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, Po Box 64900 St Paul MN 55164-0900.

When the Department receives notification that the orders are corrected, a reinspection will be

conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

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{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	{2 000}		

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{2 000}	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On September 27, 28, 2017, surveyors of this Department's staff visited the above provider and the following correction orders were not found to be corrected. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	{2 000}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 000}	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	{2 000}		
{21375}	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: "Uncorrected based on the following findings. The original licensing order issued on July 28, 2017, will remain in effect. Penalty assessment recommended." Based on observation, interview and document review, the facility failed to ensure proper hand hygiene and gloving were performed to prevent the spread of infection for 2 of 4 residents (R70, R84) observed for perineal care and wound treatment. Findings include: R70's admission record dated 9/29/17, indicated current diagnoses of quadriplegia, urinary tract infections and history of methicillin resistant staphylococcus aureus infection. Weekly wound documentation for R70 dated 9/4/17, indicated R70 had a left lower leg (rear) pressure wound, that was length 5.5 centimeter (cm) by width 4 cm unstageable, clean apply Santyl cover with	{21375}	F 441 Infection Control Immediate corrective action: NAR A, B, and C were re-educated and handwashing/glove use policy and competencies completed on ____10/18/17_____(date). LPN A was re-educated on handwashing policy and competency was completed on __9/29/17. Action as it applies to others: The Policies and Procedures for handwashing and glove use change remain current. All nursing staff have been educated for handwashing and glove use. Date of completion: __10/20/2017__ Recurrence will be prevented by: Visual audits of handwashing practices when indicated, to include proper barriers as well as hand washing and glove changing will be conducted 2x weekly x30	10/20/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	R 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED WING HEALTH CENTER	1412 WEST FOURTH STREET RED WING, MN 55066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{21375}	Continued From page 3 Optifoam, change q (every) day and prn (as needed). On 9/28/17, at 9:49 a.m., during R70's morning cares, nursing assistant (NA)-B knocked on the door and entered the room. NA-B observed to wash hands then donned gloves and proceeded to wash R70's face with wet wash cloth from a basin with water then dried R70's face with dry towel. NA-C knocked and entered R70's room, washed hands and donned gloves. NA-B continued cares and washed R70's bilateral under arms with wet wash cloth then dried under arms with dry towel. NA-C then put deodorant on R70's under arms. NA- B and NA-C donned R70's t-shirt. With R70's head of bed lowered flat, NA-B took R70's incontinence brief off and provided peri care. NA-B with the same soiled gloves placed hands on R70's body to turn resident on right side. While R70 was laying on right side, NA-C wiped R70's buttock's area with disposable wipes. NA-C confirmed R70 had a bowel movement then R70's incontinence brief was tucked under. R70 was rolled on back and NA-C proceeded to hold on to R70 to put on clean incontinence brief. NA-B and NA-C both removed soiled gloves and did not immediately wash their hands. NA-B and NA-C continued with R70's, shorts were put on along with soft booties on both feet. Then the mechanical lift sling was positioned under R70's body. NA-B dumped water out of basin. NA-C put dirty lines in clear plastic bag. NA-B along with NA-C then washed hands. During an interview on 9/28/17 at 10:10 a.m., NA-C stated, "I should have have changed gloves after cleaning his bottom, thought I washed hands after putting his shorts on." When asked what would be the expectations for hand hygiene NA-C	{21375}	days on various Units. Results will be shared with and evaluated by the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: DON/Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	R 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{21375}	Continued From page 4	{21375}		

stated that should wash hands anything after peri care and when you change gloves.

During an interview on 9/28/17 at 10:39 a.m., when asked NA-B about hand hygiene expectations she stated when you walk into the room and after anything dirty like pericare. NA-B stated when asked if she washed hands after peri care with R70 she stated she did not do it right after peri care.

During an interview with Director of Nursing (DON) on 9/28/17 at 2:17 p.m., DON's expectations for hand hygiene would be to follow policy and procedure, staff should use handsanitizer or handwashing when removing gloves. When gloves or hands are soiled staff should be washing their hands.

During an observation of a dressing change on 9/28/17 at 11:02 a.m., licensed practical nurse (LPN)-A, came in R70's room and washed hands then donned gloves. LPN-A removed dressing on R70's left calf, dressing had small amount of half circle brown drainage, LPN-A folded dressing, then set dressing on bare mattress, placed normal saline on gauze with same gloves on, then wiped wound with wet gauze, placed gauze on bare mattress with dressing, with the same gloves on grabbed another gauze patted wound dry, put dry gauze on bare mattress, with same gloves on LPN-A picked up tube of Santyl put it over eschar of wound, stated wound had more granulation tissue and still getting eschar off around wound. LPN-A put on new dressing on left calf then dated dressing. LPN-A then removed gloves and washed hands and donned new gloves. LPN-A observed to take dressing off suprapubic site. At 11:08 a.m., NA-C knocked and came into R70's room, washed hands then

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{21375}	Continued From page 5	{21375}		

donned gloves. LPN-A cleaned the catheter connection with alcohol wipe. NA-C then held catheter line as LPN-A flushed the line with a clear liquid towards R70. LPN-A put normal saline on gauze, wiped suprapubic site dry with gauze and placed a split gauze over suprapubic site. LPN-A put tape on the split gauze and dated dressing. LPN-A took gloves off. NA-C washed her hands and left the room. LPN-A adjusted resident position and washed hands and left the room.

During an interview on 9/28/17 at 1:34 p.m., when asked LPN-A if she changed gloves after old dressing was removed during the dressing change, LPN-A verified she did not change her gloves.

R84 had been observed on 9/27/17, at 1:52 p.m. after nursing assistant (NA)-A was observed washing his hands prior to going into R84's room. R84 stated he was "soaked" through to the sheet. NA-A went out of room and came back with clean linens for the bed. Clean linens were placed on the bedside table. NA-A gathered wipes and a clean incontinence brief, put on a pair of gloves and removed the top sheet from the bed and placed it on the floor at the foot of the bed. NA-A proceeded to loosen the bottom sheet from the wall side of the bed and tucked under R84's shoulder. NA-A then opened up the incontinence brief R84 was wearing and began cleaning R84's front peri area. NA-A had R84 roll towards the wall. NA-A then removed the incontinence brief R84 was wearing, wiped the rectal area with several wipes, and put a clean brief on R84. NA-A then removed the bottom sheet and the draw sheet from the bed and placed them on the floor at the foot of the bed. Without changing gloves, NA-A took the clean bottom sheet and clean draw

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	00149	A. BUILDING: _____ B. WING _____	R 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{21375}	Continued From page 6 sheet and put them under R84. Then NA-A had R84 roll onto his back again. NA-A finished putting the bottom sheet and draw sheet into place on the bed. NA-A asked R84 if he wanted a top sheet. R84 indicated that he did so NA-A put a clean top sheet over R84. NA-A then picked up the remote control for the bed and lowered bed down to lowest level. NA-A then removed his gloves and went into the bathroom and washed his hands. During an interview with Director of Nursing (DON) on 9/28/17 at 2:17 p.m., DON's expectations for hand hygiene during dressing change, was hands should be washed when gloves are donned and after soiled dressing was removed. The facility's hand washing policy dated October 2014, "Employees must wash their hands for at least 20 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: b. When hands are visibly soiled (hand washing with soap and water); h. Before and after assisting a resident with personal care (e.g., oral care, bathing); k. Before and after changing a dressing; f. After handling soiled or used linens, dressings, bedpans, catheters and urinals."	{21375}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

RECEIPT OF LICENSING PENALTY ASSESSMENT NOTICE

On October 25, 2017,

I, Dennis DeCosta, Administrator, received
(Name)(Please Print) (Title)(Please Print)
the Notice of Penalty Assessment dated October 25, 2017, and licensing orders issued to:

Red Wing Health Center
1412 West Fourth Street
Red Wing, MN 55066

The Penalty Assessments and licensing orders attached hereto have been corrected as of October 25, 2017.

Signed: Dennis DeCosta, Administrator, Date 10/25/17
(Name)(Please Print) (Title)(Please Print)

DELIVERY OF LICENSING PENALTY ASSESSMENT NOTICE

On October 25, 2017,

I, Vicky Hamersma, Nurse Evaluator II, of the Health Regulation Division,

(Name)(Please Print) (Title)(Please Print)
Minnesota Department of Health, delivered the Notice of Penalty Assessment dated and issued to:

Red Wing Health Center
1412 West Fourth Street
Red Wing, MN 55066

The Notice of Penalty Assessment was handed to Vickie Holtz,
(Name)(Please Print)
DON, Date 10.25.17
(Title)(Please Print)

Signed: [signature], DON, Date 10.25.17
(Name)(Please Print) (Title)(Please Print)

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5Z1K

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00149

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245223**
2.STATE VENDOR OR MEDICAID NO.
(L2) **955270700**

3. NAME AND ADDRESS OF FACILITY
(L3) **RED WING HEALTH CENTER**
(L4) **1412 WEST FOURTH STREET**
(L5) **RED WING, MN** (L6) **55066**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/28/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **130** (L18)
13.Total Certified Beds **130** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	130			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Jennifer Kolsrud, HFE NE II 08/22/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/03/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
11/01/1978
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
August 11, 2017

Mr. Dennis Decosta, Administrator
Red Wing Health Center
1412 West Fourth Street
Red Wing, MN 55066

RE: Project Number S5223027

Dear Mr. Decosta:

On July 28, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;
>
> Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 6, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 6, 2017 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 28, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 28, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED WING HEALTH CENTER	**1412 WEST FOURTH STREET RED WING, MN 55066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or	F 225		8/31/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/21/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED WING HEALTH CENTER	**1412 WEST FOURTH STREET RED WING, MN 55066**

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F 225	Continued From page 1	F 225		

licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate

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F 225	Continued From page 2 corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to immediately report an incident of alleged emotional abuse to the State Agency (SA)(Office of Health Facility Complaints) for 1 of 4 residents (R104) reviewed for abuse. Findings include: R104 on 7/26/17, at 8:10 a.m. was noted sitting in the dining room. R104 called this surveyor over and reported licensed practical nurse (LPN)-A "is so rude to me and I am literally afraid of her, she intimidates, scowls and a lot of tension in the air when she works." R104 indicated this is an emotional abuse to her. According to R104 this situation has been reported to the Director of Nurse, (DON) before. When R104 reported this allegation of abuse she was crying. On 7/26/17 at 8:30 a.m. two surveyors reported R104's allegation of emotional abuse to the director of nursing (DON). The DON explained to the two surveyors the situation for R104 was ongoing between the resident targeting LPN-A. DON also said, "It is related to her behavior as [LPN-A] is very competent but not cuddly." On 7/26/17, at 9:04 a.m. R104 called this surveyor and asked, "Are you sure nothing going to happen to me?" Surveyor reassured resident there should not be any retaliation for reporting the allegation of abuse. At 9:10 a.m. DON stated, "I just wanted to let you know we take abuse allegations seriously." The DON continued explaining that R104 has reported to staff of allegation of abuse against LPN-A in the past and	F 225	F 225 Immediate corrective action: LPN A was educated on 7/26/2017 on the need to administer resident 104 medications in a public place and always have a witness present when in resident 104 room due to history of false accusations against staff. The allegation against LPN A of being rude and being scared of her made by resident 104 was reported to OHFC on 7/27/2017. Action as it applies to others: The Policy and Procedure for Abuse Prevention was reviewed and remains current. Immediate education was begun for all staff on the Abuse Prevention Policy which includes timely reporting to supervisor and State reporting timelines, including immediate reporting for allegations of abuse. Date of completion: ____8/31/17_____ Recurrence will be prevented by: All resident incidents are reviewed each day and pm at Quality Conference and Quality Wrap up to assure timely reporting, investigation and follow-up. These incidents are discussed each month at QAPI and this process will continue ongoing. The correction will be monitored by: Administrator/Designee	

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F 225	Continued From page 3	F 225		

the facility educated the nurse. LPN-A was educated to give R104's medication in a public place or have another staff present in the immediate area. At 9:30 a.m. another surveyor reported R104 approached her a few minutes ago and said, "Guess I am kind of anxious, did you talk to her [DON], did you use my name? was she mad?" Resident was reassured the DON was given the allegation of abuse which R104 had reported to surveyor during an interview at 8:10 a.m. same day.

On 7/27/17, at 8:44 a.m. surveyor met with the DON and asked follow up question about R104's allegation of emotional abuse. The DON was asked if she had reported the allegation of abuse to the designated state agency. The DON indicated she had not reported the allegation of abuse because R104 was making false accusation against LPN-A.

During an interview with the social service director (SSD) at 12:26 p.m. in regards to when to report allegations of abuse/neglect, SSD stated, "I do not care if the resident has 30 cases of allegations toward staff or abuse we still have to report, it does not matter, we are not the jury we are the reporters." On asking SSD if she was aware of the allegation of abuse reported to the DON on 7/26/17 at 8:30 a.m. regarding R104's reporting abuse from the LPN.
SSD said that she was first made aware of the allegation of abuse from R104 on 7/27/17 the next day after R104 had reported it on 7/26/17. Also the allegation of emotional abuse was not reported to the Office of Health Facility Complaint (OHFC) which is the designated state agency (SA). SSD then stated, the DON asked us report the allegation of abuse made by R104 this

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F 225	Continued From page 4 morning at 9:45 a.m. During an interview on 7/28/17, at 9:54 a.m. the administrator indicated his expectation was to report such abuse allegation immediately to the SA. The facility policy titled ABUSE PREVENTION PLAN - MN dated Nov 2016 indicated, "... The administrator is ultimately in charge of the abuse prohibition plan and must be informed of all alleged or substantiated incident of abuse, neglect, or maltreatment immediately .... The state agency must also be notified immediately ..."	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum	F 226		8/31/17

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F 226	Continued From page 5 educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow their Abuse Prevention Plan regarding the immediate reporting of an incident of alleged emotional abuse to the State Agency (SA)(Office of Health Facility Compliance) for 1 of 4 residents (R104) reviewed for abuse prohibition. Findings include: The facility policy titled ABUSE PREVENTION PLAN - MN dated Nov 2016, indicated, "... The administrator is ultimately in charge of the abuse prohibition plan and must be informed of all alleged or substantiated incident of abuse, neglect, or maltreatment immediately .... The state agency must also be notified immediately ..." R104 on 7/26/17, at 8:10 a.m. was noted sitting in the dining room. R104 called this surveyor over and reported licensed practical nurse (LPN)-A "is so rude to me and I am literally afraid of her, she intimidates, scowls and a lot of tension in the air when she works." R104 indicated this is	F 226	F 226 Abuse Policy Immediate corrective action: The Report to OHFC on the incident involving resident # 104 was submitted on 7/27/2017. It should be noted due to a report being submitted the day prior on this resident for the same issue, there was some confusion and mixed guidance from the Surveyor on site as to the need to report again. Action as it applies to others: The Policy and Procedure for Abuse Prevention was reviewed and remains current. Immediate education was begun for all staff on the Abuse Prevention Policy which includes timely reporting to supervisor and State reporting timelines. Date of completion: _____8/31/17_____ Recurrence will be prevented by: All resident incidents are reviewed each day and pm at Quality Conference and Quality Wrap up to assure timely reporting, investigation and follow-up.	

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F 226	Continued From page 6 emotional abuse to her. According to R104 this situation has been reported to the Director of Nurse (DON) before. When R104 had reported her feeling, she was crying. At 8:30 a.m. two surveyors went to the DON office and reported this emotional abuse allegation to DON. The DON explained to the two surveyors the situation was ongoing with R104. This resident was targeting LPN-A. On 7/27/17, at 8:44 a.m. surveyor met with the DON and asked follow up question about R104 allegation of emotional abuse. The DON indicated she had not report the allegation because R104 was making false accusation against LPN-A. During an interview with the social service director (SSD) at 12:26 p.m. stated, "I do not care if the resident has 30 cases of allegations toward staff or abuse we still have to report, it does not matter, we are not the jury we are the reporters." SSD also explained she didn't know until the next day (7/27/17) the allegation of emotional abuse was not reported to the Office of Health Facility Complaint (OHFC). SSD stated, "The DON asked us to do the report this morning at 9:45 a.m." During an interview on 7/28/17, at 9:54 a.m. the administrator indicated his expectation was to report such abuse allegation immediately to the SA. During an interview on 7/28/17 at 8:53 a.m. DON stated RN-A should have started the abuse investigation and reported it immediately. The incident was noted on 7/6/17, at 6:18 p.m. and it was not reported to OHFC, DON or Administrator until the next morning which did not follow our policy. DON added that her expectation of timely	F 226	These incidents are discussed each month at QAPI and this process will continue ongoing. The correction will be monitored by: Administrator/Designee	

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F 226	Continued From page 7 reporting of abuse is immediately as per state regulations. Facility Policy titled Abuse Prevention Plan, effective 2012, revision November 2016, III, Components of Abuse Prevention Plan: F. 1) indicated procedure in place to report all alleged violations and substantiated incidents immediately to the State of Minnesota and take all necessary corrective action depending on the results of the investigation.	F 226		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.	F 280		8/31/17

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F 280	Continued From page 8 (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 280		

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F 280	Continued From page 9 medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a plan of care was updated and or revised to promote healing and prevent further ulcers from developing for 1 of 3 residents (R23) who developed two pressure ulcers on the right hip area. Findings include: R23 was admitted to the facility on 7/14/16, according to facility Admission Record. R23 had diagnosis that included acute respiratory failure with hypoxia, traumatic brain injury, neurogenic bowel, neuromuscular dysfunction of bladder and seizures, according to facility physician progress note dated 7/25/17. Facility identified R23 on the quarterly Minimum Data Set (MDS), 4/4/17, to have short and long term memory problem, severely impaired decision making, totally dependent on two staff for activities of daily living which included bed mobility, transfers, dressing, toileting and hygiene, always incontinent of bowel and bladder, pain unable to answer, functional limitation in range of motion on both sides, unstageable pressure ulcer due to slough or eschar, pressure	F 280	F280 Care Plans Immediate corrective action: The Care Plan for residents #23 was updated with the necessary information as soon as the omission was identified. Action as it applies to others: The Policy and Procedure for creating and maintaining current Care Plans remains current. All licensed nurses will be in-serviced on updating/maintaining Care Plans on ____8/31/17___(date). All residents with skin issues will have their Care Plans reviewed to assure the information is current and accurate. Date of completion: ___8/31/17 Recurrence will be prevented by: 3 Care Plans will be selected from random Units weekly and audited by the ID Team to assure they are accurate and comprehensive. This practice will continue x90 days and results shared with the facility QAPI committee for input on the need to increase, decrease or	

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F 280	Continued From page 10 ulcer not present on prior assessment, feeding tube, tracheostomy, suctioning, oxygen. The facility identified R23 on the annual MDS dated 6/19/17, same as 4/4/17 MDS, and was identified with no pain. R23 was observed to have two pressure ulcers on the right hip, was positioned on the right hip, and was incontinent of a large amount of urine while laying on the right hip. R23's care plan for pressure ulcer indicated the following: R23 currently had an unstageable area on right ischium (healed 4/7/17) and is at risk for more pressure ulcers. Interventions included: pressure relieving mattress on bed, treatments as ordered, notify physician/nurse practitioner if wound worsens, follow elimination care plan, turn and reposition every 2-2.5 hours assist of 2 staff, observe skin daily and weekly with bathing. Care plan problem of always incontinent of bowels and bladder. Interventions included: check incontinence product every 2 hours plus or minus 15 minutes and as needed, change as needed, provide protective skin care with each incontinence episode. Although R23's care plan indicated the pressure ulcer was healed on 4/7/17, there was no indication of two current pressure ulcers on the right hip and no staff direction to keep position off these ulcers. During observations on 7/26/17, at 8:30 a.m. to 8:58 a.m., R23 was positioned slightly on right side with a pillow to the back, facing the doorway. NA-D checked R23's incontinent brief and verified the brief and bed were wet. Observations at that time revealed the incontinent brief was heavily saturated. Observations at that time revealed NA-D provided R23 with a clean incontinent brief and clean bedding. NA-D stated R23 was to be	F 280	discontinue the audits. The correction will be monitored by: Nurse Managers/MDS Coordinators	

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F 280	Continued From page 11 repositioned every two hours. NA-D stated R23 had a wound on the right buttock. During interview on 7/27/17, at 10:51 a.m., RN-A verified R23's care plan stated right ischium pressure ulcer healed 4/7/17. RN-A verified R23's care plan was not updated when the pressure ulcers re-developed on the right hip area. During interview on 7/26/17, at 12:01 p.m., director of nursing (DON) stated she expected R23 to be repositioned every 2-2 1/2 hours according to the care plan. DON stated she expected R23 was not to be positioned on the right side where there were open skin wounds. Care Planning policy dated 11/2016: Policy-individual, resident centered care planning be initiated upon admission and maintain, by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence. In doing so, the following considerations are made: #7-Care plans should be updated between care conferences to reflect current care needs of the individual resident as changes occur. Any information updated or discontinued in the resident's care plan will include the date of the changes. Interdisciplinary team members must confer with each other prior to changing interventions that involve multiple departments to avoid miscommunication.	F 280		
F 282 SS=E	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 282		8/31/17

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F 282	Continued From page 12 (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow the care plan for 1 of 1 resident (R62) assessed to need extensive assistance with personal hygiene. Also failed to provide range of motion (ROM) exercises for 1 of 1 resident (R2) according to their plan of care, and failed to follow the care plan for 1 of 1 residents (R23), with pressure ulcers and incontinence. Findings include: R62's Minimum Data Set (MDS) dated 5/2/17, identified R62 with severe cognitive impairment and required extensive assist of 1 with personal hygiene. R62's care plan dated 6/25/15, identified R63 with an intervention of assistance with shaving or plucking facial hairs upon discovery. R62's kardex dated 7/27/17, identified R63's grooming needs assist with shaving or pluck facial hair upon discovery per R63's wishes. During observation on 7/24/17, at 4:07 p.m., R63 was sitting on the couch in the common area during a scheduled singing activity and R63 was noted to have several long unshaven chin hairs. During subsequent observations on 7/25/17, at 9:35 a.m., 7/26/17, at 12:53 a.m., and on 7/27/17, at 7:39 a.m., R63 continued to have long, unshaven, chin hairs.	F 282	F 282 Following Care Plan Immediate corrective action: Resident # 2 will receive ROM per Care Plan. Resident #23 will receive peri-care with each incontinent episode. NAR-D was counseled and re-educated on the need to provide peri-care with each incontinent episode. Resident #63 was provided a personal shaver and staff will assist to shave as needed. Action as it applies to others: The Policy and Procedure on following the Care Plan for personal needs was reviewed and remains current. The Policy and Procedure on Incontinent/Perineal care was reviewed and remains current. All residents needing staff assistance with shaving, ROM and incontinence care were reviewed to assure needs were Care Planned. All nursing staff will be in-serviced on ___8/31/17 (date) on providing needs per Care Plan/Care Card, which will include shaving, providing ROM and incontinence care. Date of completion: ___8/31/17___ Recurrence will be prevented by: Visual audits of residents weekly to assure ROM, shaving needs and incontinence care are provided will be conducted x90 days and results shared with the facility QAPI committee monthly for input on the need to increase, decrease or discontinue the audits, this	

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F 282	Continued From page 13 During interview on 7/26/17, at 1:52 p.m., nursing assistant (NA)-B verified that R63 should have had facial hair shaved. Further stated R63 does not have her own personal shaver to be shaved. When interviewed on 7/26/17, at 1:57 p.m., NA-C verifies that R63 needs extensive assist to help with shaving per the care plan and that R63 should have had her chin hairs shaved. During interview on 7/27/17, at 7:48 a.m., registered nurse (RN)-D verified that R63 should have had her chin hairs shaved and stated, "This is my worst fear living in a nursing home and to have all those facial hairs." Interview on 7/27/17, at 8:51 a.m., director of nursing (DON) verified her expectation is to shave each resident as needed and to follow the care plan as directed. DON further stated they would contact social services to get R63 a personal shaver. R2's quarterly Minimum Data Set (MDS), dated 6/21/17 identified R2 diagnoses of intracranial injury and functional quadriplegia. R2 functional limitation in ROM is impaired on both upper and lower extremities requiring R2 to be total dependent on staff for transfers and requires extensive assistance for bed mobility, dressing and personal hygiene. Record review of the visual/bedside kardex report (a report nursing assistants can review on computer of cares for the residents) identified nursing rehab/restorative staff assist of one to provide passive ROM to left upper and lower extremity 15 repetitions (reps) per joint 3 times per week.	F 282	will be monitored daily in Quality Conference. The correction will be monitored by: DON/Designee	

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R2's care plan recognizes limited range of motion. The care plan also identified R2 the need for staff to perform passive ROM to left upper extremity and left lower extremity 15 reps per joint three times a week. R2 care plan also identifies an intervention stating staff acknowledge and support R2 in her struggle with her limited mobility and offer reassurance and assistance so R2 can continue to enjoy an active lifestyle per R2's request.

Director of nursing verified in an interview on 7/27/17 at 1:01 p.m. the resident had only received one day of ROM services in the last 30 days. No evidence resident refused to do the ROM according to care plan.
R23 was admitted to the facility on 7/14/16, according to facility Admission Record.

R23 had diagnosis that included acute respiratory failure with hypoxia, traumatic brain injury, neurogenic bowel, neuromuscular dysfunction of bladder and seizures, according to facility physician progress note dated 7/25/17.

Facility identified R23 on the quarterly Minimum Data Set (MDS), 4/4/17, to have short and long term memory problem, severely impaired decision making, totally dependent on two staff for activities of daily living which included bed mobility, transfers, dressing, toileting and hygiene, always incontinent of bowel and bladder, pain unable to answer, functional limitation in range of motion on both sides, unstageable pressure ulcer due to slough or eschar, pressure ulcer not present on prior assessment, feeding tube, tracheostomy, suctioning, oxygen.

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Document review of R23's Care Area Assessment (CAA) dated 7/3/17, had triggered for urinary incontinence due to totally dependent of staff for toileting and always incontinent of bladder. Diagnosis of neurogenic bladder, has impaired mobility. Staff assist every 2-2 ½ hours and as needed.

R23 was observed to have two pressure ulcers on the right hip, positioned on the right hip, was incontinent of a large amount of urine while laying on the right hip and did not receive perineal care after urinary incontinence.

Review of R23's care plan print dated 7/26/17, included the following directions for staff:
Care plan problem of always incontinent of bowels and bladder. Interventions included: check incontinence product every 2 hours plus or minus 15 minutes and as needed, change as needed, provide protective skin care with each incontinence episode.

Document review of R23's Visual/Bedside Kardex Report (NA assignment sheet) revealed NA directed to check incontinence product every 2 hours plus/minus 15 minutes, change as needed, provide protective skin care with each incontinence.

During observations on 7/26/17, at 8:30 a.m. to 8:58 a.m., Nursing assistant (NA)-D checked R23's incontinent brief and verified the brief and bed were wet. Observations at that time revealed the incontinent brief was heavily saturated. Observations at that time revealed NA-D provided R23 with a clean incontinent brief and clean bedding. NA-D stated R23 had a wound on the right buttock. NA-D verified had not

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F 282	Continued From page 16 provided perineal care before putting new incontinent brief on resident. During interview on 7/26/17, at 10:30 a.m., LPN-B stated expected perineal care with each incontinence. During interview on 7/26/17, at 12:01 p.m., director of nursing (DON) stated she expected perineal care provided after each incontinence. Care Planning policy dated 11/2016 included, Policy-individual, resident centered care planning be initiated upon admission and maintain, by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence. Policy review dated 11/16 titled care planning reads; resident centered care planning is maintained by the interdisciplinary team through out the resident stay to promote optimal quality of life, in doing so the following considerations are made: each resident is an individual, each resident has a right to be happy, continue their life-patterns as able, resident are included in care planning and encouraged to maintain their highest practical physical and mental abilities through the nursing home stay. Care plans are accessible to all direct care staff and their responsibility to review the care plan routinely of changes.	F 282		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 312		8/31/17

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F 312	Continued From page 17 services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide assistance with shaving as directed by the care plan for 1 of 4 residents (R62) and failed to provide incontinence services/cares for 1 of 4 residents (R23) for both residents who were reviewed for activities of daily living (ADL). Findings include: R62's Quarterly Minimum Data Set (MDS) dated 5/2/17, identified R62 with severe cognitive impairment and required extensive assist of 1 with personal hygiene. R62's care plan dated 6/25/15, identified R63 with an intervention of assistance with shaving or plucking facial hairs upon discovery. R62's kardex (nursing assistant assignment for resident cares) dated 7/27/17, identified R63's grooming needs assist with shaving or pluck facial hair upon discovery per R63's wishes. During observation on 7/24/17, at 4:07 p.m., R63 was sitting on the couch in the common area during a scheduled singing activity and R63 was noted to have several long unshaven chin hairs. During subsequent observations on 7/25/17, at 9:35 a.m., 7/26/17, at 12:53 a.m., and on 7/27/17, at 7:39 a.m., R63 continued to have long, unshaven, chin hairs. During interview on 7/26/17, at 1:52 p.m., nursing assistant (NA)-B verified that R63 should have	F 312	F 312 Personal Care Immediate corrective action: Resident #23 will receive peri-care with each incontinent episode. NAR-D was counseled and re-educated on the need to provide peri-care with each incontinent episode. Resident #63 was provided a personal shaver and staff will assist to shave as needed. Action as it applies to others: The Policy and Procedure on following the Care Plan for personal needs was reviewed and remains current. The Policy and Procedure on Incontinent/Perineal care was reviewed and remains current. All residents needing staff assistance with shaving and incontinence care were reviewed to assure needs were Care Planned. All nursing staff will be in-serviced on _____8/31/17____(date) on providing needs per Care Plan/Care Card, which will include shaving and incontinence care. Date of completion: ___8/31/17_ Recurrence will be prevented by: Visual audits of residents weekly to assure shaving needs and incontinence care are provided will be conducted x90 days and results shared with the facility QAPI committee monthly for input on the need to increase, decrease or discontinue the audits, will also be discussed at daily Quality Conference. The correction will be monitored by:	

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F 312	Continued From page 18 been shaved. Further stated R63 does not have her own personal shaver to be shaved. When interviewed on 7/26/17, at 1:57 p.m., NA-C verifies that R63 needs 1 assist to help with shaving per the care plan and that R63 should have had her chin hairs shaved. During interview on 7/27/17, at 7:48 a.m., registered nurse (RN)-D verified that R63 should have had her chin hairs shaved and stated, "This is my worst fear living in a nursing home and to have all those facial hairs." Interview on 7/27/17, at 8:51 a.m., director of nursing (DON) verified her expectation is to shave each resident as needed and to follow the care plan as directed. DON further stated they would contact social services to get R63 a personal shaver. R23 was admitted to the facility on 7/14/16, according to facility Admission Record. R23 had diagnosis that included acute respiratory failure with hypoxia, traumatic brain injury, neurogenic bowel, neuromuscular dysfunction of bladder and seizures, according to facility physician progress note dated 7/25/17. Facility identified R23 on the quarterly Minimum Data Set (MDS), 4/4/17, to have short and long term memory problem, severely impaired decision making, totally dependent on two staff for activities of daily living which included bed mobility, transfers, dressing, toileting and hygiene, always incontinent of bowel and bladder, pain unable to answer, functional limitation in range of motion on both sides, unstageable pressure ulcer due to slough or	F 312	DON/Designee	

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eschar, pressure ulcer not present on prior assessment, feeding tube, tracheostomy, suctioning, oxygen.

The facility identified R23 on the annual MDS dated 6/19/17, same as 4/4/17 MDS, and was identified with no pain.

Document review of R23's Bladder and Bowel Assessment dated 6/19/17, identified risk factors included impaired mobility and dependent on two staff for transfers, currently incontinent of bladder, clothes and incontinent product is wet. Analysis indicated incontinent of bowel and bladder, has diagnosis of neurogenic bladder and staff assist R23 with all toileting needs.

Review of R23's care plan print dated 7/26/17, included the following directions for staff:
Care plan problem of always incontinent of bowels and bladder. Interventions included: check incontinence product every 2 hours plus or minus 15 minutes and as needed, change as needed, provide protective skin care with each incontinence episode.

Document review of R23's Visual/Bedside Kardex Report (NA assignment sheet) revealed NA directed to turn and reposition every 2-2.5 hours with two staff assist, R23 is unable to help at all, dependent on staff, off-load in wheelchair every 2-2.5 hours, incontinent of bowel and bladder, check incontinence product every 2 hours plus/minus 15 minutes, change as needed, provide protective skin care with each incontinence.

During observations on 7/26/17, at 8:58 a.m., nursing assistant (NA)-D entered R23's room.

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F 312	Continued From page 20 Observation at that time revealed R23 was positioned slightly on right side with a pillow to the back, facing the doorway. NA-D checked R23's incontinent brief and verified the brief and bed were wet. Observations at that time revealed the incontinent brief was heavily saturated. Observations at that time revealed NA-D provided R23 with a clean incontinent brief and clean bedding. However, no perineal care was completed before the new incontinent brief was put on the resident. NA-D verified had not provided perineal care after incontinence. 10:30 a.m., licensed practical nurse-B stated perineal care should be done after every incontinence episode. RN-A verified R23's care plan for incontinence of bowel and bladder, directed protective skin care with each incontinent episode. RN-A stated protective skin care was the use of barrier cream after each incontinence. RN-A said staff were expected to provide perineal cares with each incontinence episode. During interview on 7/26/17, at 12:01 p.m., director of nursing (DON) stated she expected perineal care provided after each incontinence. Perineal Care policy dated 10/2015 included, for male indicated-if stool present use perineal wipes, wet wash cloth and apply skin cleansing spray or use perineal wipes, wash starting with urethra and work outward, retract foreskin, wash penis, scrotum, inner thighs, gently pat dry, reposition and wash rectal area.	F 312		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		8/31/17

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F 314	Continued From page 21 (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions to promote healing for 2 of 3 residents (R23, R70) with pressure ulcers. Findings include: R23 was admitted to the facility on 7/14/16, according to facility Admission Record. According to physician notes dated 7/25/17 list of diagnosis to include acute respiratory failure with hypoxia, traumatic brain injury, neurogenic bowel, neuromuscular dysfunction of bladder and seizures. Facility identified R23 on the quarterly Minimum Data Set (MDS), 4/4/17, to have short and long term memory problem, severely impaired	F 314	F314 Pressure Ulcer Immediate corrective action: Resident 23 is able to move self in bed somewhat "scoots" himself often out of position placed into. Therapy reviewed repositioning plan for addition input. Resident 70 will be repositioned and heels floated per care plan. Action as it applies to other: All residents with PU will be reviewed to assure their repositioning needs are Car Planned. All nursing staff will be in-serviced on repositioning needs of residents on 8/31/17. Repositioning times will continue to be documented. 8/31/17 Recurrence will be prevented by: Visual audit of 3 residents weekly needing staff	

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F 314	Continued From page 22 decision making, totally dependent on two staff for activities of daily living which included bed mobility, transfers, dressing, toileting and hygiene, always incontinent of bowel and bladder, pain unable to answer, functional limitation in range of motion on both sides, unstageable pressure ulcer due to slough or eschar, pressure ulcer not present on prior assessment, feeding tube, tracheostomy, suctioning, oxygen. The facility identified R23 on the annual MDS dated 6/19/17, same as MDS dated 4/4/17, and was identified with no pain. Document review of R23's Tissue Tolerance an assessment to evaluate pressure to areas that include bony prominence and prolonged pressure which could cause damage to tissue. See the following: 3/28/17-no redness throughout evaluation, is on a pressure reducing mattress, reposition every 2-2 ½ hours. 4/28/17-no redness throughout evaluation, remain on 2-2 ½ hour reposition schedule. 6/2/17- no redness noted, is on a pressure reducing mattress, reposition every 2 -2 ½ hours. Document review of facility Braden Scale Assessment for Predicting Pressure Sore Risk dated 4/28/17, and 6/2/17, revealed R23 was at high risk for developing pressure sore, skin very moist; chair fast-ability to walk severely limited or non-existent; mobility very limited-makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently; friction and shear are a problem-requires moderate to maximum assistance moving, complete lifting without sliding against sheets is impossible,	F 314	assistance with reposition to assure compliance and documentation of times will be conducted x 90 days and results shared monthly with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. the correction will be monitored by: DON/Designee	

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frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance, spasticity, contractures or agitation leads to almost constant friction.

Document review of facility Comprehensive Evaluation of Skin Inspection and Risk Factors dated 4/28/17, revealed R23 was at high risk for developing pressure sore; other risk factors included head of bed elevated majority of the day, required assist with activities of daily living, had medical devices such as oxygen tubing; diagnosis if brain injury; had right ischium unstageable pressure ulcer measuring 2 centemeters (cm) by 1 cm by 0.1 cm depth. Analysis indicated R23 was at risk for developing pressure ulcer related to immobility, already existing pressure injury, assistance with all mobility and incontinence, pressure relieving mattress in place, remains on a turn and reposition every two hours.

Document review of facility Comprehensive Evaluation of Skin Inspection and Risk Factors dated 6/2//17, revealed all areas same as 4/28/17 assessment, except the right gluteal fold unstageable pressure ulcer measured 4 cm by 1.5 cm by 0.05 cm depth. Analysis indicated R23 wound had worsened since hospital stay, is larger and deeper, continue to do dressing changes daily, turn and reposition every 2-2 ½ hours, up in wheelchair a couple times a day and requires two staff assist with turning and repositioning in wheelchair and with all mobility.

Document review of R23's Care Area Assessment (CAA) dated 7/3/17, revealed triggered for pressure ulcer related to totally dependent with bed mobility, always incontinent

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of bowel and bladder, and had a pressure ulcer on right ischium unstageable. Required special mattress and wheelchair cushion.

Review of R23's care plan print dated 7/26/17, revealed the following directions for staff:
R23 currently had an unstageable area on right ischium (healed 4/7/17) and is at risk for more pressure ulcers. Interventions included: pressure relieving mattress on bed, treatments as ordered, notify physician/nurse practitioner if wound worsens, follow elimination care plan, turn and reposition every 2-2.5 hours assist of 2 staff, observe skin daily and weekly with bathing. Care plan problem of always incontinent of bowels and bladder. Interventions included: check incontinence product every 2 hours plus or minus 15 minutes and as needed, change as needed, provide protective skin care with each incontinence episode.

Document review of R23's Visual/Bedside Kardex Report (a Nursing Assistant [NA] assignment sheet) revealed NA directed to turn and reposition every 2-2.5 hours with two staff assist, R23 is unable to help at all, dependent on staff, off-load in wheelchair every 2-2.5 hours, incontinent of bowel and bladder, check incontinence product every 2 hours plus/minus 15 minutes, change as needed, provide protective skin care with each incontinence.

The following observations and interviews were dated 7/26/17 at 7:02 a.m. R23 was observed asleep in low bed, and fall mat on floor by bed. R23 was positioned slightly on the right side with a pillow at the back. R23 was positioned facing the doorway. At 7:18 a.m., licensed practical nurse (LPN)-B, entered R23's room, discontinued

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the tube feeding and started a nebulizer treatment. R23 remained in the same position slightly on the right side facing the door. At 7:27 a.m., same position as at 7:02 a.m.

During observations on 7/26/17, at 8:21 a.m., LPN-B entered R23's room, discontinued the nebulizer treatment. During interview at that time, LPN-B verified had not repositioned R23 at that time. R23 was observed positioned slightly on the right side with a pillow at the back. R23 was positioned facing the doorway. At 8:30 a.m., same position, slightly on right side facing the door. At 8:45 a.m., same position, slightly on right side facing door with a pillow at the back. At 8:52 a.m., LPN-B entered R23's room, asked if R23 needed anything. LPN-B explained would get R23 up in a while. R23 remained positioned slightly on the right side, facing the door. At 8:58 a.m., nursing assistant (NA)-D entered R23's room. Observation at that time revealed R23 was positioned slightly on right side with a pillow to the back, facing the doorway. NA-D checked R23's incontinent brief and verified the brief and bed were wet. Observations at that time revealed the incontinent brief was heavily saturated. Observations at that time revealed NA-D provided R23 with a clean incontinent brief and clean bedding. No red areas were observed on the visible areas of right hip and back. NA-D stated R23 was to be repositioned every two hours. NA-D stated R23 had a wound on the right buttock. Observation at that time revealed one right wound dressing with hand written date of 7/26/17, 2:00 a.m. During interview at that time, NA-D verified R23 had a large urine incontinence. NA-D verified had not provided perineal care after incontinence. At 9:11 a.m., NA-D verified did not know when R23 had last been repositioned or

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checked for incontinence. At 9:12 a.m., NA-D and nursing assistant (NA)-A, positioned R23 on the left side, facing the window, with pillows at the back and between the legs. NA-D and NA-A verified R23 had a wound on the right buttocks. At 9:24 a.m., NA-A stated NA-G had completed R23's morning cares. They stated all residents cares are done between 7:00 a.m., and 8:00 a.m. At 9:39 a.m., NA-G stated had not completed morning cares for R23. NA-G stated R23's morning cares were completed by the night shift at 6:30 a.m., which included washing, dressing, perineal care and repositioning. NA-G stated R23 was repositioned between 8:00 a.m., and 8:30 a.m., by LPN-B. At 9:45 a.m., LPN-B verified went to R23's room at 8:21 a.m., removed nebulizer treatment. LPN-B verified did not do any cares for R23 at that time. LPN-B and NA-A, stated the facility does not document repositioning for R23. LPN-B stated expected repositioning of R23 every two hours. LPN-B stated R23 would have been repositioned between 6:00 a.m. to 6:30 a.m., by the night shift. LPN-B verified the facility had no documentation of when R23 was repositioned. At 10:30 a.m., LPN-B stated expected perineal care with each incontinence. At 11:04 a.m., NA-A, NA-G and registered nurse (RN)-A, were observed to transfer R23 from wheel chair to bed with a mechanical lift, removed slacks, and positioned on left side facing the window while RN-A provided wound care to the right hip wound. Observations at that time revealed two foam dressings on the right hip located near each other. RN-A removed the smaller foam dressing to reveal a reddened area located on the right hip bone area. RN-A removed the larger foam dressing on the right hip to reveal one unstageable ulcer with a large amount of tan

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drainage on the dressing and foul odor. RN-A cleansed the wound with sterile water, applied medi-honey to the white eschar. The wound appeared approximately 3 centimeters with white eschar in the center, edges were dark pink in color. Review of the medi-honey pharmacy label with dispense date of 7/25/16, revealed to apply to wound every eight hours. RN-A covered both wounds with foam dressings. R23 was positioned on the left side facing the window with pillows to the back and between the legs. RN-A stated the right hip red area was new. RN-A stated she does wound care on Mondays and staff nurses complete wound care the rest of the week. RN-A verified medi-honey treatment started on 7/25/17. RN-A stated the facility had issues with faxing order to pharmacy and issues with pharmacy delivering the medi-honey. RN-A verified medi-honey had been ordered but not delivered for several days. RN-A stated physician had been notified of not starting the medi-honey when ordered. RN-A stated R23 was scheduled for debridement of the wound recently, was canceled due to issue with transportation and no nurse to go with R23 to the appointment. RN-A stated R23 was rescheduled for debridement on 7/31/17, at 1:00 p.m. RN-A described the wound as unstageable with eschar, outside eschar area is stage 4, and dressing soaked with tan drainage. RN-A stated the foam dressing could also have been soaked with urine due to the large incontinence. RN-A stated it was usual for R23 to have wound dressing soaked. RN-A stated she expected R23 to be repositioned every two hours, from back to left side and back to back again. RN-A stated she was aware R23 was positioned on the right side, same side as the right hip wound, and faced the doorway. RN-A stated the smaller red area on the right hip was probably

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from facing door for sometime, positioned on the right hip. RN-A stated the red area on right hip had appeared before and then goes away. RN-A stated she expected perineal care after each incontinence. RN-A verified the unstageable pressure ulcer had declined.

On 7/27/17 at 12:01 p.m., director of nursing (DON) stated she expected R23 to be repositioned every 2-2 ½ hours according to the care plan. DON stated she expected R23 was not to be positioned on the right side open wound. DON stated she expected perineal care after each incontinence.

The following observations and interviews were dated 7/27/17 at 8:15 a.m. R23 was in bed on left side facing the window with a pillow to the back. During interview at that time, LPN-B stated R23 was just repositioned and LPN-B would do dressing change later. At 9:30 a.m., interview nursing assistant (NA)-H who stated R23 was to be repositioned every two hours and checked for incontinence every two hours. NA-H stated had cared for R23, who had a wound on the right hip (new fracture) and was not to be positioned on the right side. NA-H stated would provide pericare after each incontinence. At 9:35 a.m., interview nursing assistant (NA)-I stated R23 was to be repositioned every two hours and checked for incontinence every two hours. NA-I stated there is a kardex with instructions for care inside the closet door. NA-I stated had cared for R23, who had a wound on the right hip and was not to be positioned on the right side. NA-I stated would provide pericare after each incontinence. At 10:35 a.m., observations revealed NA-H positioned R23 to the left side while RN-A provided the dressing changes to the right

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ischium. RN-A removed the smaller foam dressing to right hip to reveal red area which measured 3 cm by 2 cm, blanchable and no drainage. RN-A applied a foam dressing to the red area. RN-A removed larger right hip dressing, saturated with tan drainage, wound measured 5.5 cm by 3.9 cm by 1.1 cm and 2 cm depth, with 75 percent eschar per RN-A. RN-A cleansed the wound with sterile water, applied medi-honey and covered the wound with a white absorbent dressing. RN-A and NA-H positioned R23 onto back with pillows between the legs. At 10:51 a.m., interview RN-A verified was aware R23 had previously been positioned on his right side, unstageable wound on the morning of 7/26/17. RN-A stated the night staff thought they were doing the right thing by placing R23 on the right side, off of left hip fracture.

Reviewed Weekly Wound Documentation Forms with RN-A and during the review RN-A stated the facility Weekly Wound Documentation Forms dated 6/19/17 to 7/24/17, which identified one unstageable pressure ulcer on the right ischium. During interview at this time, RN-A verified the right ischium wound was found on 3/28/17, and was measured on 3/31/17, to be 1 cm by 1 cm, and unstageable. RN-A stated she expected tissue tolerance evaluation completed whenever a wound develops and with every return from the hospital. RN-A verified R23's care plan stated right ischium pressure ulcer healed 4/7/17 which was a different ulcer. RN-A verified R23's care plan was not revised to include the new ulcer found on 3/28/17. RN-A verified R23 was hospitalized from 4/23/17 to 4/28/17, with fecal impaction. RN-A verified the 5/4/17 physician progress note identified a left hip fracture, had a fall prior to hospitalization, and very difficult to

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determine if the fracture occurred at the nursing home. RN-A verified physician progress note dated 5/4/17, identified one- stage 2 decubitus right ischial ulceration, found prior to hospitalization, appears to be worse. RN-A verified R23's care plan for incontinence of bowel and bladder, directed protective skin care with each incontinent episode. RN-A stated protective skin care was the use of barrier cream after each incontinence. RN-A stated the care plan lacked direction to provide perineal care after incontinence because perineal care is a standard order of care, staff were expected to provide with each incontinence. RN-A verified the facility had no way to identify when R23 was repositioned and checked for incontinence. RN-A stated R23 may be dry all night and then have a large incontinence. RN-A verified physician order dated 7/14/17, to reposition every two hours, and verified the care plan directed reposition every 2-21/2 hours. RN-A verified physician order dated 7/17/17, for medi-honey to the wound, and verified the treatment did not start until 7/25/17 when the ointment arrived, a period of eight days after the order. RN-A stated staff made attempts to obtain medi-honey. RN-A verified physician progress note dated 7/25/17, in which the physician identified R23's prior debridement was canceled and physician ordered right hip x-ray. RN-A stated the debridement was canceled due to not having the right transportation, procedure had been rescheduled a week later and canceled due to no staff available to go with R23. RN-A stated the right hip x-ray was completed on 7/25/17, at 1:00 p.m., and debridement was scheduled for 7/31/17, at 1:00 p.m. RN-A verified physician progress note 4/11/17, identified visit was for a fall and head laceration overnight and unstageable pressure ulcer found on 3/28/17.

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RN-A verified Weekly Wound Documentation Form dated 4/7/17 and progress note dated 4/13/17, identified right ischial wound healed.
RN-A verified R23 sustained a fall from bed on 4/11/17, with a head laceration and was seen by the physician on 4/11/17. RN-A verified R23 was hospitalized 4/23/17 to 4/28/17, for evaluation of the left hip fracture.
RN-A verified significant change progress note dated 4/23/17, which identified a large red area approximately 5 cm by 3 cm and inside the red area was an open area measured 3 cm by 1 cm on right buttock upper thigh crease. RN-A stated R23 was sent to the hospital on 4/23/17, for evaluation of left hip fracture. RN-A verified R23 developed right ischial ulcer on 3/28/17, healed on 4/7/17, developed again on 4/23/17, measuring 5 cm by 3 cm and 3 cm by 1 cm open, hospitalized on 4/23/17, and returned 4/28/17 with wound worsened.

Document review of facility Weekly Wound Documentation Form revealed the following:
3/31/17-pressure (ulcer) right ischium 1 centimeter (cm) by 1 cm, unstageable, no drainage, no odor.
analysis-wound unchanged, continue current plan. treatment-repositioning and barrier cream.
4/7/17-pressure right ischium, 0 cm by 0 cm, unstageable,no odor, improved. analysis- wound is healed.
treatment-repositioning and barrier cream.
5/5/17- pressure right ischium, 2 cm by 1 cm by 0.1 cm depth, unstageable, no drainage, no odor, improved.
analysis-on bedrest related to hip fracture, pressure reducing mattress in place, cover with foam daily.

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F 314	Continued From page 32 5/11/17-pressure right ischium, 2 cm by 0.8 cm by 0.1 cm depth, unstageable, no drainage, no odor, improved. analysis- on bedrest related to hip fracture, pressure reducing mattress in place, cover with foam daily. 5/19/17-pressure right ischium, 3 cm by 0.5 cm, by 0.1 cm depth, unstageable, no odor, no drainage, stable. analysis-turn and reposition every 2 -2.5 hours. cover with foam daily. 6/12/17-pressure right ischium, 2.8 cm by 0.5 cm by 0.1 cm depth, unstageable, no drainage, no odor, improved, analysis-remains on 2-2.5 hour reposition, wound remains same. Cleanse with wound wash, santyl (a collagenase ointment used as an enzymatic debriding ointment) to eschar, cover with foam dressing, change daily. 6/19/17-pressure right ischium, 3 cm by 4 cm by 0.5 cm depth, pressure, unstageable, no drainage, no odor, progress is no change, analysis-remains same size, turn and reposition every 2-2.5 hours, cleanse with wound wash, santyl to eschar, cover with foam dressing, change daily. 6/28/17-pressure right ischium, 3.6 cm by 2.8 cm by 0.5 cm depth, stage 3, moderate serosanguinous drainage, no odor, progress-no change, analysis-remains same size, reposition every 2-2.5 hours. cleanse with wound wash, santyl to eschar, cover with foam dressing, change daily. 7/4/17-pressure right ischium, 4.7 cm by 3.1 cm, no depth identified, unstageable, scant and moderate drainage, serosanguinous and green drainage	F 314		

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F 314	Continued From page 33 odor-yes, cleanse with wound wash, santyl to eschar, cover with foam dressing, change daily. analysis- augmentin (antibiotic) two times a day, continue with current dressing change, remains on reposition every 2-2.5 hours. 7/17/17-pressure right ischium, 5 cm by 3 cm by 1.3 cm depth, unstageable, scant drainage, serosanguinous, no odor, cleanse with wound wash, santyl to eschar, cover with foam dressing, change daily, progress-declined, analysis- no longer has green drainage, eschar is loosening and depth is able to be measured, remains on reposition every 2-2.5 hours, refer to physician for surgical/mechanical debridement for left ischium unstageable pressure ulcer. 7/24/17-pressure right ischium, 5 cm by 3.5 cm by 2 cm depth stage 4, heavy drainage, tan color, no odor, right ischial wound care-cleanse with wound wash, apply medi-honey to eschar/slough, cover with foam dressing, change every 8 hours, analysis-continue current treatment of medi-honey, has appointment on 7/31/17 for debridement of wound. Document review of facility progress notes revealed the following: On 4/23/17 R23 on rounds at 12:00 a.m. had large red area approximately 5 cm by 3 cm, inside red area is open area 3 cm by 1 cm, on right buttock upper thigh crease.	F 314		

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On 6/2/17-returned from hospital about 1 p.m. today, continues to have trachea in, wound on right gluteal fold measures 4 cm by 1.5 cm and 0.5 cm in depth, had worsened since left the facility. Also indicated on 6/2/17, R23 was lying on right side in bed at 40 degrees angle.

On 7/19/17 upon cares at 8:30 a.m., R23 appeared to have no foam dressing over right hip wound, this has happened multiple times in last week, also laying on right side and not on the left side. The note stated brief lines exactly on top of wound, complete bed change and put pad under R23 so brief would not irritate the wound. The note indicated a new mark above the wound that measured 5.3 cm by 3.5 cm.

On 7/22/17 a red area on right hip measured 2.5 cm by 3 cm and blanchable.

Document review of progress notes related to lack of medi-honey that was ordered on 7/17/17 indicated that on
7/19/17, 7/20/17, and 7/25/17, staff called the facility pharmacy to obtain medi-honey.

Document review of the right hip x-ray dated 7/25/17, revealed degenerative joint disease of right hip and no evidence to indicate osteomyelitis at this time.

Document review of physician orders revealed the following orders with start date:
On 7/14/17-reposition every 2 hours.
On 7/17/17-right ischial wound care, clean with wound wash, apply medi-honey to eschar/slough, cover with foam dressing, change every 8 hours.

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F 314	Continued From page 35 On 7/25/17-X-ray right hip (evaluate for possible osteomyelitis). Document review of physician/nurse practitioner progress notes revealed the following: On 3/14/17-skin warm and dry, no suspicious lesions or wounds. On 4/11/17- sustained a fall overnight and unstageable pressure ulcer was found 3/28/17, on ischium. On 5/4/17-was hospitalized 4/23/17 to 4/28/17 for fecal impaction. Diagnosis included right hip fracture diagnosed incidentally during hospitalization, did have a fall prior to hospitalization. Diagnosis also indicated a stage two decubitus right ischial ulceration found prior to hospitalization, appears to be worse. On 6/5/17-during assessment visit, the sacral wound was found to have no dressing in place. Skin warm and dry, has right ischial tuberosity that is non-stageable, approximately 4 cm by 1.5 cm covered with black eschar and approximately 0.5 erythema around the perimeter, no drainage, no induration. The note indicated R23 was in the emergency room over the week-end for elevated temperature, constipation and chest x-ray revealed infiltrates and started on antibiotics. On 6/9/17-impression is pneumonia. On 7/14/17-ordered to reposition every 2 hours to prevent excessive pressure to the area. R23 has been referred to general surgery, had an appointment previously but was discontinued due to lack of staff at the facility to accompany to the appointment. Will reschedule this for a very needed debridement. On 7/25/17- revealed R23 was seen for acute visit for follow up of right ischial pressure ulcer. R23 was last seen on 7/14/17. R23 had a scheduled appointment with surgery on 7/7/17,	F 314		

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for debridement of pressure ulcer. Physician was told by healthcare coordinator today that this appointment was canceled due to no nursing staff available to accompanying R23. Physician was told no follow-up appointment had been made. Nursing reports ulceration is malodorous, increased drainage, possible pain, pain medication given with good effect. Right ischial pressure ulceration was examined, wound bed appears to be necrotic and larger than last exam. R23 had significant grimacing when physician palpated the edges of wound. Wound was malodorous. There is a 2 cm red area on right hip that is blanchable. Medi-honey was ordered after last provider visit, which physician was told, had not yet been started . There is also a new area on right hip, which per nursing notes on 7/22/17, showed a 2.5 cm red area which is blanchable. A foam has been applied to this area. Physician assessment and plan-unstageable right ischial ulceration. Will do a right hip X-ray to assess for possible osteomyelitis, will consider doing CT scan due to contractures, ordered blood work, previous wound culture was polymicrobial and was on augmentin (antibiotic) for 10 days. Physician spoke to nursing about medi-honey as it is currently not available. Nursing said it was coming in today at 2 p.m. Physician asked for appointment for debridement as this was canceled without physician knowing. Physician told the facility this is medically necessary and should not be postponed.

Document review of hospital Consultation report dated 4/23/17, revealed reason for exam was abdominal pain and fever. Also noted right buttocks stage 1 decubitus ulcer, no erythema, induration, drainage, bleeding or warmth, mepilex border reapplied.

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Document review of nursing progress notes revealed the following:
On 4/11/17-unstageable pressure ulcer found on ischium on 3/28/17.
On 4/23/17-has large red area approximate 5 cm by 3 cm inside red area is open area 3 cm by 1 cm on right buttock upper thigh crease, area cleansed and foam dressing applied, positioned to off- load pressure in the area.
On 7/23/17-nursing progress note identified orders-right ischial wound, clean with wound wash, apply medihoney to eschar/slough, cover with foam dressing, change every 8 hours.

During interview on 7/25/17 at 9:33 a.m., R23's medical doctor (MD)-A stated R23 had a new unstageable pressure ulcer which started in the facility. MD-A stated on three occasions found no dressing on the wound and have found R23 positioned on the unstageable wound. MD-A stated not aware the debridement appointment was canceled because no staff were available to go with R23 to the appointment. MD-A stated had changed the wound treatment recently to medi-honey and was not aware that the facility had not obtained the ointment timely.

During interview on 7/26/17, at 12:01 p.m., director of nursing (DON) stated she expected R23 to be repositioned every 2-2 1/2 hours according to the care plan. DON stated she expected R23 was not to be positioned on the right side open wound. DON stated she expected perineal care after each incontinence.

During interview on 7/28/17, at 10:11 a.m., RN-A stated R23 had repositioned self to the right side on her own.

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R70's Minimum Data Set (MDS) dated 5/11/17, indicated R70 had no cognitive impairment, required assistance of two persons for bed mobility and had a diagnosis of quadriplegia. The MDS further indicated R70 had one stage III pressure ulcer and was at risk of developing a pressure ulcer. The MDS also indicated R70 had a pressure reducing device for his chair and bed, received pressure ulcer care and applications of ointments/medications. R70's Visual/Bedside Kardex Report printed on 7/27/17, indicated he was to be assisted with turning and repositioning every 2 hours-2.5 hours with an assist of two staff members and off load when in his wheel chair every 2 hours. The report further indicated R70 was to have a heel elevating cushion to keep heels off the bed all the time, and to be checked for incontinence every 2 hours.

R70's Treatment Administration Record (TAR) dated 1/16/16, indicated that every shift the nurse was to ensure that staff were following care plan for turning, repositioning and documentation. A Turn and Reposition and Offloading Per Care Plan Task Sheet for R70 did not have check marks for every shift on 14 days between 6/27/17, and 7/25/17. A Tissue Tolerance (TT) was conducted on 7/14/17, with plan for R70 to remain on a 2-2.5 hours turn and reposition schedule.

Skin Assessment progress notes from 4/7/17, through 7/26/17, revealed the following: 4/17/17, left lateral heel measurement only: length, 1 centimeter (cm) x width 1 cm x unstageable depth. 5/11/17, left lateral heel measurement only: 1.5 x 1.2 x stage III. 6/12/17, left lateral foot measurements: anterior: 0.4 x 0.2 x unstageable and posterior 1 x 1.02 x

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unstageable. 7/24/17, left lateral foot measurements: anterior 0.5 x 0.5 x unstageable and posterior 0.25 x 0.25 unstageable. 7/26/17, right heel scar tissue 1.5 x 1.0 and coccyx: 4.5 x 4 x stage II.

During continuous observation on 7/26/17, from 7:05 a.m. to 10:24 a.m. (3 hours and 19 minutes) R70 was observed laying in his bed on his back without being repositioned (off loaded) or checked for incontinence. At 10:24 a.m. writer queried two staff members in hallway, Registered Nurse (RN)-A and RN-B, and voiced concern regarding repositioning of resident. Resident was subsequently repositioned and his right heel was raised off of the bed.

On 7/26/17, at 10:40 a.m. during an interview, RN-A confirmed R70 had not been turned or repositioned since 7:05 a.m. and his right heel had been resting on the bed. RN-A and RN-B confirmed there was a quarter sized darkened area on R70's right heel and his skin over the coccyx area had a half dollar sized pink/white area. RN-A stated R70 should be checked on, turned and repositioned every 2 hours and his heels should have been elevated off of the bed.

On 7/26/17, at 11:05 a.m. during an interview with R70 he stated he is not turned and repositioned for over 3 hours every shift and when that happens I get stiff and worry about my skin opening up.

On 7/26/17, at 12:39 p.m. during an interview with Nursing Assistant (NA)-A confirmed R70 should be turned and repositioned every two hours.

On 7/27/17, at 7:56 a.m. during an interview,

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DON stated her expectations for turning and repositioning residents would be based on assessments and reflected in the resident's care plan.

On 7/27/17, at 8:24 a.m. during an interview, RN-A stated she had reviewed R70's wounds and he had a new pressure ulcer to his coccyx area that was not present one week ago and his right heel has an area of scar discoloration which she will monitor to see if it is a pressure ulcer or old scar tissue. RN-A further indicated that turning and repositioning of R70 needs to be done every two hours or wounds could develop.

On 7/27/17, at 1:53 p.m. during an interview, RN-A stated documentation by NAs had multiple missing check marks under R-70's turning and repositioning log between 6/27/17, and 7/25/17, so it was not known if R70 was repositioned or not on those shifts.

The facility Prevention of Pressure Ulcers Policy and Procedures dated 2/2014, General Preventive Measures for a Person in Bed directed staff to change resident's position at least every two hours or more frequently if needed.

Pressure Ulcer stages defined by the National Pressure Ulcer Advisory Panel (NPUAP):

Stage 1: Nonblanchable Erythema: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.

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Stage 2: Partial Thickness Skin Loss: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising.

Stage 3 Pressure Ulcer: Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough (yellow devitalized tissue, that can be stringy or thick and adherent on the tissue bed) and/or eschar (dark, dead tissue) may be visible. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Ulcer.

Stage 4 Pressure Ulcer: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Ulcer.

Unstageable Pressure Ulcer: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

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Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration. Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4).

Policies provided by facility:
Prevention of Pressure Ulcers dated 2/2014:
General Guidelines:
Indicated pressure ulcers are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area and subsequent destruction of tissue. The most common site of a pressure ulcer is where the bone is near the surface of the body. pressure ulcers are often made worse by continual pressure, heat, moisture, irritating substances on resident's skin (i.e., perspiration, feces, urine, wound discharge, soap residue, etc) decline in nutrition and hydration status, acute illness and/or decline in resident's physical and / or mental condition.
Interventions and Preventive Measures-indicated change position at least every 2 hours or more frequently if needed. Place resident on a minimum of a 2 hour check and change program.
Risk Factor-Bowel and Bladder Incontinence-check for incontinence at least every 2 hours and clean skin when soiled.

Perineal Care policy dated 10/2015:

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F 314	Continued From page 43 For male indicated-if stool present use perineal wipes, wet wash cloth and apply skin cleansing spray or use perineal wipes, wash starting with urethra and work outward, retract foreskin, wash penis, scrotum, inner thighs, gently pat dry. reposition and wash rectal area. Skin Program policy dated 9/2016: Indicated to ensure a resident who enters the facility without pressure ulcers does not develop pressure ulcers unless the individuals clinical condition demonstrates that they were unavoidable. on admission, baseline assessment of skin status done within 2 hours of admission. further comprehensive skin assessments will be done with readmission, annually, and change of condition or surface comprehensive wound assessment will be completed when a skin ulcer is identified.	F 314		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;	F 315		8/31/17

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F 315	Continued From page 44 (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide necessary cares/services to prevent urinary tract infections (UTI) for 2 of 2 residents (R64, R125) reviewed for urinary catheter. Findings include: R64 was admitted to the facility 8/18/15 according to the admission sheet. Review of the medical record indicate R64 to have current diagnoses of urinary obstruction, urinary retention (inability to completely empty the bladder), hydrocele (an accumulation of fluid around the testicles), phimosis (an inability to retract the foreskin over the penis) and a urinary tract infection (UTI). During an observation on 7/26/17, at 7:15 a.m.	F 315	F315 Incontinence Care Immediate corrective action: Catheter care was provided to resident # 64 as soon as the discrepancy was identified. Resident #125 catheter tubing and bag were repositioned up from floor. Action as it applies to others: The Policy and Procedure for Urinary Catheter Care was reviewed and remains current. All residents with catheters will be assessed to assure catheter care is identified on Care Plan and Care Card and added to Tx Sheets for nurses to validate completion Catheter care competencies will be conducted on all nursing staff by ____8/31/17_____(date). This will	

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F 315	Continued From page 45 R64 was in bed with the catheter bag cover unsnapped and the lower quarter of the catheter bag uncovered and in direct contact with the floor. At 8:12 a.m. nursing assistant (NA)-J entered the room to assist with morning care and did not provide pericare or catheter care during the partial bath. NA-J assisted R64 to wheelchair while holding catheter bag above resident bladder. When interviewed, NA-J stated she had received no training at the facility related to the provision of catheter care and it was briefly taught during her nursing assistant course the previous fall. NA-J was unaware of the need to keep catheter bag below the bladder level to prevent urine from reentering into the bladder. NA-J unable to recall any training in catheter cleaning instruction. During an interview on 7/26/17, at 1:57 p.m. with licensed practical nurse (LPN)-A, she was unable to find providing catheter care on the treatment sheet for R64 and unable to state if it was being provided. An interview with registered nurse (RN)-A on 7/28/17, at 8:34 a.m. revealed that NAs have access to the plan of care and that providing catheter care is delegated to the NAs and the nurse is responsible to see that it is done. Document review for R64 including a note from urology dated 1/17/17, directed staff to "please complete pericare for pt [patient/R64]!" A note from the medical doctor, indicated on 7/20/17, resident had become more somnolent and less interactive. The current care plan included instruction to keep catheter bag below the bladder but no direction related to providing	F 315	include proper positioning of tubing and bags. Date of completion: __8/31/17_____ Recurrence will be prevented by: Visual audits of catheter care to include tubing and bag placement will be conducted on residents weekly x90 days to assure the procedure is being completed according to Care Plan. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: DON/Designee	

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catheter care.
R125's Minimum Data Set (MDS) dated 5/4/17, indicated R125 had moderate cognitive impairment, a diagnosis of malignant bladder cancer and an indwelling Foley catheter.

Care Plan dated 5/4/17, identified R125 needed assistance with urinary function related to R125 having an indwelling Foley catheter.

Medical doctor (MD) progress note dated 6/16/17, identified R125 had Alzheimer's dementia. This is severe, and he is unable to make his own medical decisions.

Medical Doctor Orders identified R125 was on antibiotics for a UTI from 5/13 -5/23/17, and another UTI from 5/31/17 - 6/7/17.

Observation on 7/24/17, at 3:30 p.m., R125 was lying in bed sleeping with the Foley catheter tubing running down his left leg and the catheter bag was in a blue cloth bag lying directly on the floor in front of the bed.

On 7/25/17, at 10:19 a.m., R125 was sitting in his wheelchair in his room with the catheter bag lying on the floor as R125 was trying to wheel self forward and was running over the catheter tubing with the wheel chair tire.

On 7/26/17, at 8:39 a.m., R125 observed to be sleeping in bed with wheelchair parked in front of the bed and catheter bag still connected to left side of wheelchairs arm rest.

On 7/27/17, at 7:10 a.m., R125 observed wheeling self in wheelchair down the hall towards the common area. R125's catheter bag was

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hanging off the left side of his armrest of his wheelchair. Dark yellow urine is noted to be pooled in the bottom of the catheter tubing that is dragging on the floor.

Interview on 7/27/17, at 7:59 a.m., nursing assistant (NA)-E stated that R125 always puts his catheter bag on the left side of his arm rest on his wheelchair because he transfers himself. NA-E further stated she did not realize that urine could backflow into R125's bladder if the catheter bag was not positioned below the bladder level and therefore putting R125 at a higher risk to develop a UTI.

On 7/27/17, at 8:12 a.m., R125 observed to be wheeling self to dining room with his catheter bag hanging off the wheelchairs left arm rest and urinary tubing was coiled and dragging on the floor, R125 was running over his own tubing until this surveyor notified RN-D of the event. During this time RN-D stated that R125's urine is unable to drain with his catheter bag hanging off the left side of his arm rest on his wheelchair. RN-D further stated, "I don't know what the answer is ...I just want to get him up to the table so he can eat."

During interview on 7/27/17, at 8:53 a.m., director of nursing (DON) verified her expectation would be to have the resident's catheter bag to be hanging below the bladder to allow proper drainage of urine and to help prevent a UTI.

A policy, "Urinary Catheter Care," dated 2010, revised November 2016, indicates to check the resident frequently to be sure he is not lying on the catheter and to keep the catheter and tubing free of kinks. The urinary drainage bag must be

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F 315	Continued From page 48 held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. Infection Control identifies, be sure the catheter tubing and drainage bag are kept off the floor.	F 315		
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to maintain range of motion (ROM) exercises for 1 of 1 residents (R2) to prevent further decrease in range of motion. Findings include: R2's quarterly Minimum Data Set (MDS), dated 6/21/17 identified R2 diagnoses of intracranial injury and functional quadriplegia. R2 functional limitation in ROM is impaired on both upper and lower extremities requiring R2 to be total dependent on staff for transfers and requires extensive assistance for bed mobility, dressing and personal hygiene. R2's brief interview	F 318	F 318 ROM Immediate corrective action: Resident # 2 was provided ROM per Care Plan as soon as omission was identified. Action as it applies to others: The Policy and Procedure for providing ROM remains current. All residents will be assessed to assure all who need assisted ROM have been identified and Care Planned. All nursing staff will be in-serviced on the need to provide ROM per Care Plan/Care Card. Date of completion: ___8/31/17_____	8/31/17

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F 318	Continued From page 49 memory score (BIMS) dated 6/21/17 identified a score of 14 indicating intact cognition Record review of document titled visual/bedside kardex report (a report nursing assistants can review on computer of cares for the residents.) identified nursing rehab/restorative staff assist of one to provide passive ROM to left upper and lower extremity 15 reps per joint 3 times week. Interview on 7/26/17 at 12:29 p.m. with R2 regarding therapy she receives, when asked if she receives therapy she stated, "Nope." Asked R2 is she was comfortable in her chair she stated, "Nope, I want to lay down," and pushed her call light on. R2's nursing progress notes identified no notes of refusal or indication why passive ROM was not completed for the past six months. Interview on 7/26/17 at 12:47 p.m. with nursing assistant (NA)-B. Stated she is familiar with the resident and requires a lot of assistance with positioning but can help assist to role side to side in bed. Interview on 7/27/17 at 11:33 a.m. with NA-F stated R2 is dependent on staff, but can help roll in bed. NA also added when positioning, R2 does not have pain and does not refuse. Interview on 7/27/17 at 12:26 p.m. with director of nursing (DON) stated the documentation for the ROM was in Point of Care (POC a computer program where NA's document). DON verified in the computer where to find the information with the surveyor, which identified one day of therapy in the last 30 days. DON stated would have to	F 318	Recurrence will be prevented by: Visual audits will be conducted on 3 residents weekly x90 days to assure ROM is occurring per Care Plan/Care Card. The results of these audits will be shared monthly with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: DON/Designee	

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F 318	Continued From page 50 verify the documentation of refusal but would expect her staff to document ROM even any refusal so staff can further assessment can be completed or a change. Follow up on 7/27/17 at 1:01 p.m. from the DON verifying no documentation found regarding the refusal or additional documents verifying R2 received the ROM. DON was able to print from POC a look back of 30 days which only identified on 7/10/17 ROM was completed. DON stated the facility has a restorative aide that would complete the ROM services. DON stated the restorative aide is pulled to the floor to care for the residents and not able to complete ROM for the those who required the services Policy review dated 1/14/14 titled restorative nursing program reads; documentation of resident restorative progress will be assessed and documented quarterly by the Registered Nurse manager in progress notes. These notes will include analysis of participating, goals, results, need for any alterations, to remain the same or discontinue.	F 318		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures	F 431		8/31/17

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F 431	Continued From page 51 that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431		

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F 431	Continued From page 52 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain insulin medication for 5 of 5 residents (R135, R92, R8, R67, and R86) at a safe temperature for use in 1 of 3 medication refrigerators reviewed, failed to dispose of expired medications, and did not label short term medications with the date opened to determine when the medication would outdate. Findings include: LACK OF MONITORING TEMPERATURES FOR STORAGE OF INSULIN AND OTHER TEMPERATURE SENSITIVE MEDICATIONS: During the initial tour of the 3 West medication room on 7/24/17, at 2:10 p.m. the medication refrigerator thermometer was observed to read 29 degrees Fahrenheit (F) and the Licensed practical nurse (LPN)-C verified the reading. No temperature log present. LPN-C stated a log used to be posted on the front of the refrigerator but had not seen one lately. On 7/27/17, at 9:49 a.m. during a review of medication room on 3 West, LPN-D noted the refrigerator temperature read 27 degrees F. LPN-D confirmed a count of thirty six unopened insulin pens labeled for R135, R92, R8, R67, R86, and 2 unopened vials of insulin from the emergency kit (e-kit). No temperature log present. LPN-D stated that she had previously asked for a refrigerator log but had not received one. On 7/27/17, at 1:41 p.m. medication room 3 West, a review of medication room refrigerator	F 431	F 431 Storage of Medication Immediate corrective action: The Insulin was moved from refrigerator identified and temperature was adjusted. Outdated/unlabeled medications identified were discarded Action as it applies to others: All medication refrigerators were reviewed to assure they were maintaining proper temperature range and had logs for documenting temperatures. All licensed nurses were in-serviced on the Storage of Medication Policy which includes proper temperature for medications stored in refrigerators, recording on the temperature log, and alerting maintenance if the temperature is above or below the range identified on the log on _____8/31/17_____(date). Education also included the need to date medications when opened and the process for checking medcarts for expired medications. Date of completion: ____8/31/17_____ Recurrence will be prevented by: All medication refrigerators will be checked weekly to assure temperatures are maintaining the range identified and logs are current and accurate. All medcarts will be checked weekly for dating when opened and for expired medications. This audit will continue x90 days and results shared with the facility QAPI monthly for input on the need to	

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F 431	Continued From page 53 temperature read 34 degrees F. LPN-D verified temperature. No temperature log present. During an interview on 7/27/17, at 5:17 p.m. Director of Nursing (DON) notified of refrigerator temperature variations and stored insulin. On 7/28/17, at 9:08 a.m. LPN-C verified refrigerator temperature reads 39 F. Temperature log present. On 7/28/17, at 9:23 a.m. Pharmacy Consultant stated per manufacturer (Sanofi) insulin should be kept at a temperature no lower than 36 degrees F. and the facility should keep a temperature log for the medication room refrigerator. On 7/28/17, at 11:18 a.m. Temperature taken using surveyor digital thermometer read 41.5 F in comparison with facility thermometer reading of 40 F a the same time. Noted all the Insulin had been removed from the refrigerator. The facility's Medication Storage policy, June 2016, indicates the refrigerator temperature range is between 36-38 degrees F., monthly tracking sheets for all refrigerators to record temperatures, and nursing staff will check and record temperatures daily. EXPIRED MEDICATIONS: During an audit of the medication cart on 3 west on 7/24/17, at 1:49 p.m. noted 1 can of beneprotein with a best use date of 7/21/17. On the treatment cart 1 jar of silvadine, expiration date of 6/2017, was verified by LPN-C.	F 431	increase, decrease or discontinue the audits. The correction will be monitored by: DON/Designee	

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F 431	Continued From page 54 While auditing the medication room on 2 east on 7/24/17/at 5:52 p.m., 1 vial of e-kit lorazepam was noted. Expiration date of 2/2017 which was verified by LPN-A. During an audit of medication room on 2 west on 7/26/17 at 11:30 a.m. 1 bottle of vancomycin, expiration date 7/8/17, and stock cathflo activase expiration date 7/2016, and a fluvirin injection expiration date 7/2015, verified by registered nurse (RN)-B. LACKED OPEN DATE TO DETERMINE CORRECT OUTDATE: During an audit of the medication cart on 3 west, LPN-C verified a vial of Haldol which was opened and had no opened on date, a vial of insulin which was open had no opened on date, and 1 bottle of Flonase that was open had no opened on date. During an interview with RN-B, regarding who has responsibility for checking the medications for expiration dates. RN-B stated she feels it is everyone's responsibility to check medications as pharmacy does not check them to her knowledge. The facility policy for Storage of Medications, revised on 1/17 indicates no discontinued, outdated, or deteriorated medications/ solutions are destroyed.	F 431		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention	F 441		8/31/17

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F 441	Continued From page 55	F 441		

and control program (IPCP) that must include, at a minimum, the following elements:

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

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F 441	Continued From page 56 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene procedures were followed by staff for 1 of 1 resident (R64) observed receiving morning care to prevent the spread of infection. Findings include: R64 had been observed on 7/26/17, at 8:39 a.m. when nursing assistant (NA)-J failed to wash her hands after providing morning cares which included using wipes as R64 had been incontinent of stool. NA-J disposed R64's soiled brief in a plastic bag. NA-J removed her gloves and left R64's room, taking the bag containing the soiled brief. NA-J had not washed her hands	F 441	F 441 Infection Control Immediate corrective action: NAR-J was re-educated and handwashing immediatley. Action as it applies to others: The Policy and Procedure for handwashing remains current. All nursing staff will be re-educated and competencies completed for handwashing on ____8/31/17_____(date). Date of completion: ____8/31/17_____ Recurrence will be prevented by: Visual audits of handwashing practices when indicated will be conducted 3x weekly x90 days on various Units.	

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F 441	Continued From page 57 following cares for R64 and immediately at 8:40 a.m. NA-J was observed going into another resident's room approached the bedside, uncovered resident and asked the resident if she would like to get up for breakfast. NA-J donned gloves in the room, then stated "let me get the lift." NA-J left the resident's room and retrieved the standing lift. When NA-J returned to the resident's room, she was asked about handwashing. NA-J verified she had not washed her hands after removing gloves and doing peri care for R64. NA-J stated I usually go out to the nursing desk after cares and wash hands, but just got nervous today. According to the facility policy dated 10/14 entitled Handwashing/Hygiene, employees must wash their hands for at least twenty (20) seconds before and after assisting a resident with personal care and after handling soiled or used linens.	F 441	Results will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: DON/Designee	
F 456 SS=B	483.90(d)(2)(e) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION (d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. (e) Resident Rooms Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 residents (R2) with cracked wheelchair armrest had equipment maintained in functional working order.	F 456	F 456 Maintenance Immediate corrective action: The W/C arm and strap for resident #2 was immediately replaced/repaired.	8/31/17

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F 456	Continued From page 58 Findings include: R2's wheelchair had been observed on 7/26/17 at 12:29 p.m. the right wheelchair arm on R2's wheelchair were noted to be torn and cracked, with exposure to the metal frame as well as one of the foot straps were broken off and hanging down towards the floor. R2 had been asked if the facility offered to fix the arm of the wheelchair. R2 stated, "Nope!" R2 care plan reads, "I do use a wheelchair for mobility." The intervention is for staff to monitor for unpleasant odors and clean/replace wheelchair cushions/covers/equipment when needed. During an interview on 7/27/17 at 11:31 a.m. with registered nurse (RN)-A stated when things need to be fixed or replaced staff are to update the maintenance department on their computer program called "TELL." Interview on 7/27/17 at 12:54 p.m. with director of nursing (DON) stated the facility cannot fix R2 wheelchair because hers is custom and if they attempt can void the warranty of the manufacturer. R2 is placed in her custom wheelchair on a daily basis. DON stated her expectation of staff would have reported the damage to the wheelchair maker before now. Interview with DON on 7/27/17 at 2:19 p.m. in which the DON supplied the surveyors with daily audits completed for each room including resident equipment. DON reviewed the audits and verified there was no documentation, which would have identified R2 damage to the	F 456	Action as it applies to others: The preventive maintenance program is current. All staff will be educated on the need to identify and report any equipment repairs needed promptly. The ID Team will be re-educated on the need to identify and report equipment repair needs during daily rounding. Date of completion: _____8/31/17_____ Recurrence will be prevented by: Daily rounds will occur 5x weekly to review environmental concerns including resident equipment. The results of these rounds will be discussed at the Quality Conference and Quality Wrap-up meetings. This will be an ongoing process with results shared monthly at the facility QAPI committee. The correction will be monitored by: Administrator/Maintenance Director	

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F 456	Continued From page 59 wheelchair. Interview with administrator on 7/28/17 at 9:38 a.m. stated each wing is gone through daily to identify areas that need addressed. Administrator stated the wheel chair should been identified during unit manager daily rounds. Policy regarding the maintenance of resident equipment was requested, but not supplied.	F 456		
F 465 SS=B	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an environment that was clean, sanitary and in good repair for 5 of 89 resident rooms, 1 of 1 resident (R86) rooms with leaking bathroom ceiling and hallways, tub rooms, dining room and family lounge. Findings include: The following rooms and concerns were	F 465	F 465 Maintenance Immediate corrective action: The areas identified on 200 and 300 areas of carpet loose/stained, peeling plaster, closet door room 20-2, hanging cable, stained ceiling tiles, missing ceiling tiles and dead insects will be repaired/replaced/removed. Action as it applies to others: The preventive maintenance program is current.	8/31/17

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F 465	Continued From page 60 observed during a tour with the administrator on 7/28/17, at 8:30 a.m. 2E8-2- bathroom ceiling tile with large brown stains. 2E20-2-closet door off the tracks and leaned against the wall. 2E44-2-TV cable hanging down near the doorway. 3W61-During observations of R86's room on 7/26/17, at 10:50 a.m., a live ant and dead green long tailed flying bugs called midges, were observed on the counter between two closets, dead ant on bathroom sink, live ant on bathroom floor, many dead gnats and dead midges on bedside stand and on the window sill. Observations during the environment tour with the Administrator on 7/28/17, at 8:30 a.m., revealed dead gnats (small flying bug) on bedside stand, large area of hard plastic on bathroom ceiling instead of ceiling tile, with approximately 3 inches wide area the length of the plastic that exposed pipes above the ceiling. During interview at that time, Administrator stated the facility has a roof leak, the hose is draining water from the roof into the wastebasket (which is located next to the toilet). Administrator verified ceiling pipes were visible. Administrator verified bugs on the bedside stand. Administrator stated pest control was at the facility every 30 days. Document review of facility Grievance/Concern Report Form dated 3/15/17, revealed hand written concern of leak in R86's bathroom ceiling. A temporary fix was put into place several weeks ago which included a pipe draining into a bucket. No further action had been taken by the facility.	F 465	All maintenance staff will be re-educated on the need to follow the regularly scheduled maintenance and room repair to include carpet, ceiling tiles, fan dust, closet doors, and dead insect removal. Date of completion: _____8/31/17_____ Recurrence will be prevented by: Daily rounds will occur 5x weekly to review environmental concerns including resident rooms and common areas for needed repairs. The results of these rounds will be discussed at the Quality Conference and Quality Wrap-up meetings. This will be an ongoing process with results shared monthly at the facility QAPI committee. The correction will be monitored by: Administrator/Maintenance Director	

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F 465	Continued From page 61 This concern was brought up by the Ombudsman. Action taken was offered to move R86 to another room, R86 refused to move. 3w68-2-3 bathroom tile with brown stains, tape covering door latch. 3w80-1-bathroom ceiling tile with brown stains. 200 wing east tub room-missing ceiling tile. 200 west wing carpet stained and loose in areas. 300 wing hallway carpets stained. 300 wing family lounge peeling plaster, brown ceiling stains. 300 wing dining room doorway with peeling plaster, brown stains on ceiling above doorway. 300 north wing-free standing fan on 300 north hall thick dust. Although a policy was requested, none was provided that addressed maintenance of the building. During interview at the time of the tour on 7/28/17, at 8:30 a.m., Administrator verified the areas of concern. He stated nurses use the computer system to notify maintenance director of needed repairs. Maintenance director checks this every day. Facility has quality council meeting every morning and afternoon where department heads report on their assigned rounds room checks.	F 465		
F 520 SS=F	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance.	F 520		8/31/17

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F 520	Continued From page 62 (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:	F 520		

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F 520	Continued From page 63 Based on interview and document review, the facility failed to identify quality concerns, and failed to ensure the committee participated in development and oversite of implementation of facility policies and systems to ensure quality of life and quality of care were maintained for the following citations issued on the previous survey with exit date of 8/5/16 which affects 80 of 80 residents currently residing in the facility. Findings include: Refer to F225 as the facility failed to report allegations of emotional abuse for 2 of 3 residents (R104 and R27) in a timely manner. Refer to F226 as the facility failed to operationalize the Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property policy and enforce a resident environment that was free from abuse for 2 of 3 residents (R104 and R27). Refer to F282 as the facility failed provide qualified staff to complete cares areas for 4 of 5 residents (R62, R2, R23 and R64). R62 for shaving, R2 for range of motion, R23 for pressure ulcers, R64 for catheter care and R23 for incontinence care. Refer to F318 as the facility failed to record and follow up on missing range of motion services to 1 of 1 resident (R2). Refer to F441 as the facility staff had not performed hand washing in between cares of residents. On 7/28/17 at 11:35 a.m. The administrator was	F 520	F 520 Immediate corrective action: The facility QAPI Committee will meet to review the areas identified in the facility 2567 as soon as it is received and an Action Plan will be developed. Action as it applies to others: The Facility QAPI Plan policy and procedure is current as to process. The facility will enlist the assistance of the Corporate Quality Director to review the facility's QAPI Plan, meeting content, RCA, Action Plans, and follow-up. The ID Team will be re-educated on the QAPI process by the Corporate Quality Director on __8/16/17_____(date). Date of completion: _____8/31/17_____ Recurrence will be prevented by: Weekly Audits of the Facility QAPI Action Plan areas will be conducted by different members of the ID Team to assure progress and consistency is maintained. These audits will be discussed monthly at the QAPI meeting and changes made according to outcomes. This will be an ongoing process. The correction will be monitored by: Administrator/DON	

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F 520	Continued From page 64 interviewed about their quality assurance (QA). The administrator stated their QA committee meets monthly, and identified who attended as well, as how they would identify issues in the facility. The administrator stated the director of nursing and the administrator oversee the program and sets the expectations. The administrator further stated each department head is responsible for their department but recognizes some have different experiences and help guide them. The administrator recognized the repeated deficiencies and stated they still have some work to do.	F 520		

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Red Wing Health Center) was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Electronically Signed — 08/18/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Red Wing Health Center is a 3-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1965 and was determined to be of Type II(222) construction. In 1972, addition was constructed to the West Wing that was determined to be of Type II(222) construction. In 1999 a small addition was added to the west wing. Because the original building and the 2 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 130 beds and had a census of 80 at the time of the survey.	K 000		
K 291	NFPA 101 Emergency Lighting	K 291		9/11/17

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K 291 SS=F	Continued From page 2 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 Findings Include: On facility tour between 09:00 AM and 01:00 PM on 7/27/2017, based on documentation review and interview that the following include: The Facility does not have copy of emergency lighting testing monthly and annual test This deficient practice could affect the safety of all the residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 291	K 291 Emergency Lighting is tested monthly by facility Maintenance Department. Documentation of testing will be recorded and maintained by the Director of Maintenance. Documentation will be reviewed by QAPI Committee for 90 days. 09/11/17	
K 324 SS=D	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply	K 324		9/11/17

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K 324	Continued From page 3 with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		
	This STANDARD is not met as evidenced by: Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2		K 324 Facility kitchen hood has been inspected. Documentation of the inspection shall be maintained annually by the Director of Maintenance. The kitchen hood inspection will be scheduled annually by the Maintenance Director. 09/11/17	

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K 324	Continued From page 4 Findings Include: On facility tour between 09:00 AM and 01:00 PM on 7/27/2017, based on documentation review and interview that the following include: The Facility does not have a annual kitchen hood inspection reports. This deficient practice could affect the safety of all the residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 324		
K 351 SS=E	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is not met as evidenced by: Spinkler System - Installation 2012 EXISTING	K 351	K 351 Missing ceiling tiles in room 20 and room 1043 have been installed. The	9/11/17

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K 351	Continued From page 5 Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Findings Include: On facility tour between 09:00 AM and 01:00 PM on 7/27/2017, based on observation and interview revealed that the following include: They were missing ceiling tiles in room 20 a storage and dining room 1043. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartments. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 351	facility Maintenance Director shall be responsible for ceiling tile installation. Ceiling tile inspection will be part of routine rounds of the building by Maintenance Director. 09/11/17	
K 372 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction	K 372		9/11/17

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K 372	Continued From page 6 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 7/27/2017, based on observation and interview revealed that the following include: We found penetrations above ceiling in the smoke barrier on 2nd and 3rd floors. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment.	K 372	K 372 The penetrations above the ceiling in the smoke barrier on 2nd and 3rd floors have been properly sealed. The Maintenance Director shall be responsible for any work which may create a penetration to ensure penetration is properly sealed and maintained. 09/11/17	

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K 372	Continued From page 7 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 372		
K 521 SS=F	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is not met as evidenced by: HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Findings Include: On facility tour between 09:00 AM and 01:00 PM on 7/27/20, based on observation and interview revealed that the following include: The ventilation system on the 1st, 2nd, and 3rd floors in the 1965 addition utilizes the egress corridor as the return air for the resident rooms. This deficient practice could affect the safety of all the residents, staff and visitors within the this addition from 1965. This deficient practice was confirmed by the	K 521	K 521 Please see attached waiver. 08/17/2017 Red Wing Health Center requests a waiver for the K521. The facility is documented to be fully sprinklered and has auto shutoff of the HVAC system. Additionally, evidence that corrective action would pose an unreasonable hardship on the facility. Cost to improve HVAC system would cost approximately $530,000. It is also estimated that such work would disrupt the normal use of patient areas for at least 6 months.	9/11/17

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 521	Continued From page 8 Facility Maintenance Director at the time of discovery.	K 521		

DEPARTMENT OF HEALTH

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 11, 2017

Mr. Dennis Decosta, Administrator
Red Wing Health Center
1412 West Fourth Street
Red Wing, MN 55066

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5223027

Dear Mr. Decosta:

The above facility was surveyed on July 24, 2017 through July 28, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gary Nederhoff, Unit Supervisor at (507) 206-2731 or at gary.nederhoff@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	07/28/2017

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On July 24, 25, 26, 27, & 28, 2017, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to identify quality concerns, and failed to ensure the committee participated in development and oversite of implementation of facility policies and systems to ensure quality of life and quality of care were maintained for the following citations issued on the previous survey with exit date of 8/5/16 which affects 80 of 80 residents currently residing in the facility. Findings include:	2 255	see POC	8/31/17

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2 255	Continued From page 3 Refer to F225 as the facility failed to report allegations of emotional abuse for 2 of 3 residents (R104 and R27) in a timely manner. Refer to F226 as the facility failed to operationalize the Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property policy and enforce a resident environment that was free from abuse for 2 of 3 residents (R104 and R27). Refer to F282 as the facility failed provide qualified staff to complete cares areas for 4 of 5 residents (R62, R2, R23 and R64). R62 for shaving, R2 for range of motion, R23 for pressure ulcers, R64 for catheter care and R23 for incontinence care. Refer to F318 as the facility failed to record and follow up on missing range of motion services to 1 of 1 resident (R2). Refer to F441 as the facility staff had not performed hand washing in between cares of residents. On 7/28/17 at 11:35 a.m. The administrator was interviewed about their quality assurance (QA). The administrator stated their QA committee meets monthly, and identified who attended as well, as how they would identify issues in the facility. The administrator stated the director of nursing and the administrator oversee the program and sets the expectations. The administrator further stated each department head is responsible for their department but recognizes some have different experiences and help guide them. The administrator recognized the repeated deficiencies and stated they still have some work to do.	2 255		

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2 255	Continued From page 4 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow the care plan for 1 of 1 resident (R62) assessed to need extensive assistance with personal hygiene. Also failed to provide range of motion (ROM) exercises for 1 of 1 resident (R2) according to their plan of care, and failed to follow the care plan for 1 of 1 residents (R23), with pressure ulcers and incontinence. Findings include: R62's Minimum Data Set (MDS) dated 5/2/17,	2 565	see POC	8/31/17

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2 565	Continued From page 5 identified R62 with severe cognitive impairment and required extensive assist of 1 with personal hygiene. R62's care plan dated 6/25/15, identified R63 with an intervention of assistance with shaving or plucking facial hairs upon discovery. R62's kardex dated 7/27/17, identified R63's grooming needs assist with shaving or pluck facial hair upon discovery per R63's wishes. During observation on 7/24/17, at 4:07 p.m., R63 was sitting on the couch in the common area during a scheduled singing activity and R63 was noted to have several long unshaven chin hairs. During subsequent observations on 7/25/17, at 9:35 a.m., 7/26/17, at 12:53 a.m., and on 7/27/17, at 7:39 a.m., R63 continued to have long, unshaven, chin hairs. During interview on 7/26/17, at 1:52 p.m., nursing assistant (NA)-B verified that R63 should have had facial hair shaved. Further stated R63 does not have her own personal shaver to be shaved. When interviewed on 7/26/17, at 1:57 p.m., NA-C verifies that R63 needs extensive assist to help with shaving per the care plan and that R63 should have had her chin hairs shaved. During interview on 7/27/17, at 7:48 a.m., registered nurse (RN)-D verified that R63 should have had her chin hairs shaved and stated, "This is my worst fear living in a nursing home and to have all those facial hairs." Interview on 7/27/17, at 8:51 a.m., director of nursing (DON) verified her expectation is to shave each resident as needed and to follow the	2 565		

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2 565	Continued From page 6	2 565		

care plan as directed. DON further stated they would contact social services to get R63 a personal shaver.
R2's quarterly Minimum Data Set (MDS), dated 6/21/17 identified R2 diagnoses of intracranial injury and functional quadriplegia. R2 functional limitation in ROM is impaired on both upper and lower extremities requiring R2 to be total dependent on staff for transfers and requires extensive assistance for bed mobility, dressing and personal hygiene.

Record review of the visual/bedside kardex report (a report nursing assistants can review on computer of cares for the residents) identified nursing rehab/restorative staff assist of one to provide passive ROM to left upper and lower extremity 15 repetitions (reps) per joint 3 times per week.

R2's care plan recognizes limited range of motion. The care plan also identified R2 the need for staff to perform passive ROM to left upper extremity and left lower extremity 15 reps per joint three times a week. R2 care plan also identifies an intervention stating staff acknowledge and support R2 in her struggle with her limited mobility and offer reassurance and assistance so R2 can continue to enjoy an active lifestyle per R2's request.

Director of nursing verified in an interview on 7/27/17 at 1:01 p.m. the resident had only received one day of ROM services in the last 30 days. No evidence resident refused to do the ROM according to care plan.
R23 was admitted to the facility on 7/14/16, according to facility Admission Record.

R23 had diagnosis that included acute respiratory

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2 565	Continued From page 7	2 565		

failure with hypoxia, traumatic brain injury, neurogenic bowel, neuromuscular dysfunction of bladder and seizures, according to facility physician progress note dated 7/25/17.

Facility identified R23 on the quarterly Minimum Data Set (MDS), 4/4/17, to have short and long term memory problem, severely impaired decision making, totally dependent on two staff for activities of daily living which included bed mobility, transfers, dressing, toileting and hygiene, always incontinent of bowel and bladder, pain unable to answer, functional limitation in range of motion on both sides, unstageable pressure ulcer due to slough or eschar, pressure ulcer not present on prior assessment, feeding tube, tracheostomy, suctioning, oxygen.

Document review of R23's Care Area Assessment (CAA) dated 7/3/17, had triggered for urinary incontinence due to totally dependent of staff for toileting and always incontinent of bladder. Diagnosis of neurogenic bladder, has impaired mobility. Staff assist every 2-2 ½ hours and as needed.

R23 was observed to have two pressure ulcers on the right hip, positioned on the right hip, was incontinent of a large amount of urine while laying on the right hip and did not receive perineal care after urinary incontinence.

Review of R23's care plan print dated 7/26/17, included the following directions for staff:
Care plan problem of always incontinent of bowels and bladder. Interventions included: check incontinence product every 2 hours plus or minus 15 minutes and as needed, change as needed, provide protective skin care with each

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2 565	Continued From page 8	2 565		

incontinence episode.

Document review of R23's Visual/Bedside Kardex Report (NA assignment sheet) revealed NA directed to check incontinence product every 2 hours plus/minus 15 minutes, change as needed, provide protective skin care with each incontinence.

During observations on 7/26/17, at 8:30 a.m. to 8:58 a.m., Nursing assistant (NA)-D checked R23's incontinent brief and verified the brief and bed were wet. Observations at that time revealed the incontinent brief was heavily saturated. Observations at that time revealed NA-D provided R23 with a clean incontinent brief and clean bedding. NA-D stated R23 had a wound on the right buttock. NA-D verified had not provided perineal care before putting new incontinent brief on resident.

During interview on 7/26/17, at 10:30 a.m., LPN-B stated expected perineal care with each incontinence.

During interview on 7/26/17, at 12:01 p.m., director of nursing (DON) stated she expected perineal care provided after each incontinence.

Care Planning policy dated 11/2016 included, Policy-individual, resident centered care planning be initiated upon admission and maintain, by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence.

Policy review dated 11/16 titled care planning reads; resident centered care planning is maintained by the interdisciplinary team through out the resident stay to promote optimal quality of

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2 565	Continued From page 9 life, in doing so the following considerations are made: each resident is an individual, each resident has a right to be happy, continue their life-patterns as able, resident are included in care planning and encouraged to maintain their highest practical physical and mental abilities through the nursing home stay. Care plans are accessible to all direct care staff and their responsibility to review the care plan routinely of changes. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required	2 570		8/31/17

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2 570	Continued From page 10 by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a plan of care was updated and or revised to promote healing and prevent further ulcers from developing for 1 of 3 residents (R23) who developed two pressure ulcers on the right hip area. Findings include: R23 was admitted to the facility on 7/14/16, according to facility Admission Record. R23 had diagnosis that included acute respiratory failure with hypoxia, traumatic brain injury, neurogenic bowel, neuromuscular dysfunction of bladder and seizures, according to facility physician progress note dated 7/25/17. Facility identified R23 on the quarterly Minimum Data Set (MDS), 4/4/17, to have short and long term memory problem, severely impaired decision making, totally dependent on two staff for activities of daily living which included bed mobility, transfers, dressing, toileting and hygiene, always incontinent of bowel and bladder, pain unable to answer, functional limitation in range of motion on both sides, unstageable pressure ulcer due to slough or eschar, pressure ulcer not present on prior assessment, feeding tube, tracheostomy, suctioning, oxygen. The facility identified R23 on the annual MDS dated 6/19/17, same as 4/4/17 MDS, and was identified with no pain. R23 was observed to have two pressure ulcers on the right hip, was positioned on the right hip, and was incontinent of a large amount of urine while laying on the right hip.	2 570	see POC	

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2 570	Continued From page 11 R23's care plan for pressure ulcer indicated the following: R23 currently had an unstageable area on right ischium (healed 4/7/17) and is at risk for more pressure ulcers. Interventions included: pressure relieving mattress on bed, treatments as ordered, notify physician/nurse practitioner if wound worsens, follow elimination care plan, turn and reposition every 2-2.5 hours assist of 2 staff, observe skin daily and weekly with bathing. Care plan problem of always incontinent of bowels and bladder. Interventions included: check incontinence product every 2 hours plus or minus 15 minutes and as needed, change as needed, provide protective skin care with each incontinence episode. Although R23's care plan indicated the pressure ulcer was healed on 4/7/17, there was no indication of two current pressure ulcers on the right hip and no staff direction to keep position off these ulcers. During observations on 7/26/17, at 8:30 a.m. to 8:58 a.m., R23 was positioned slightly on right side with a pillow to the back, facing the doorway. NA-D checked R23's incontinent brief and verified the brief and bed were wet. Observations at that time revealed the incontinent brief was heavily saturated. Observations at that time revealed NA-D provided R23 with a clean incontinent brief and clean bedding. NA-D stated R23 was to be repositioned every two hours. NA-D stated R23 had a wound on the right buttock. During interview on 7/27/17, at 10:51 a.m., RN-A verified R23's care plan stated right ischium pressure ulcer healed 4/7/17. RN-A verified R23's care plan was not updated when the pressure ulcers re-developed on the right hip area. During interview on 7/26/17, at 12:01 p.m., director of nursing (DON) stated she expected	2 570		

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2 570	Continued From page 12 R23 to be repositioned every 2-2 1/2 hours according to the care plan. DON stated she expected R23 was not to be positioned on the right side where there were open skin wounds. Care Planning policy dated 11/2016: Policy-individual, resident centered care planning be initiated upon admission and maintain, by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence. In doing so, the following considerations are made: #7-Care plans should be updated between care conferences to reflect current care needs of the individual resident as changes occur. Any information updated or discontinued in the resident's care plan will include the date of the changes. Interdisciplinary team members must confer with each other prior to changing interventions that involve multiple departments to avoid miscommunication. SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise policies and procedures related to ensuring the care plan for each individual resident is updated and revised. The director of nursing could educate licensed staff to update and revise care plans. The director of nursing could develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities	2 895		8/31/17

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2 895	Continued From page 13 through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to maintain range of motion (ROM) exercises for 1 of 1 residents (R2) to prevent further decrease in range of motion. Findings include: R2's quarterly Minimum Data Set (MDS), dated 6/21/17 identified R2 diagnoses of intracranial injury and functional quadriplegia. R2 functional limitation in ROM is impaired on both upper and lower extremities requiring R2 to be total dependent on staff for transfers and requires extensive assistance for bed mobility, dressing and personal hygiene. R2's brief interview memory score (BIMS) dated 6/21/17 identified a score of 14 indicating intact cognition Record review of document titled visual/bedside kardex report (a report nursing assistants can review on computer of cares for the residents.) identified nursing rehab/restorative staff assist of one to provide passive ROM to left upper and lower extremity 15 reps per joint 3 times week.	2 895	see POC	

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2 895	Continued From page 14 Interview on 7/26/17 at 12:29 p.m. with R2 regarding therapy she receives, when asked if she receives therapy she stated, "Nope." Asked R2 is she was comfortable in her chair she stated, "Nope, I want to lay down," and pushed her call light on. R2's nursing progress notes identified no notes of refusal or indication why passive ROM was not completed for the past six months. Interview on 7/26/17 at 12:47 p.m. with nursing assistant (NA)-B. Stated she is familiar with the resident and requires a lot of assistance with positioning but can help assist to role side to side in bed. Interview on 7/27/17 at 11:33 a.m. with NA-F stated R2 is dependent on staff, but can help roll in bed. NA also added when positioning, R2 does not have pain and does not refuse. Interview on 7/27/17 at 12:26 p.m. with director of nursing (DON) stated the documentation for the ROM was in Point of Care (POC a computer program where NA's document). DON verified in the computer where to find the information with the surveyor, which identified one day of therapy in the last 30 days. DON stated would have to verify the documentation of refusal but would expect her staff to document ROM even any refusal so staff can further assessment can be completed or a change. Follow up on 7/27/17 at 1:01 p.m. from the DON verifying no documentation found regarding the refusal or additional documents verifying R2 received the ROM. DON was able to print from POC a look back of 30 days which only identified on 7/10/17 ROM was completed. DON stated the	2 895		

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2 895	Continued From page 15 facility has a restorative aide that would complete the ROM services. DON stated the restorative aide is pulled to the floor to care for the residents and not able to complete ROM for the those who required the services Policy review dated 1/14/14 titled restorative nursing program reads; documentation of resident restorative progress will be assessed and documented quarterly by the Registered Nurse manager in progress notes. These notes will include analysis of participating, goals, results, need for any alterations, to remain the same or discontinue. SUGGESTED METHOD FOR CORRECTION: The administrator could implement a restorative program to provide range of motion services for residents. The DON could provide staff training on the program and implement policies and procedures related to range of motion services. The DON could monitor to assure residents receive proper range of motion treatment. The quality assurance and assessment committee could audit to ensure ongoing compliance TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home	2 900		8/31/17

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2 900	Continued From page 16 without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions to promote healing for 2 of 3 residents (R23, R70) with pressure ulcers. Findings include: R23 was admitted to the facility on 7/14/16, according to facility Admission Record. According to physician notes dated 7/25/17 list of diagnosis to include acute respiratory failure with hypoxia, traumatic brain injury, neurogenic bowel, neuromuscular dysfunction of bladder and seizures. Facility identified R23 on the quarterly Minimum Data Set (MDS), 4/4/17, to have short and long term memory problem, severely impaired decision making, totally dependent on two staff for activities of daily living which included bed mobility, transfers, dressing, toileting and hygiene, always incontinent of bowel and bladder, pain unable to answer, functional limitation in range of motion on both sides, unstageable pressure ulcer due to slough or eschar, pressure ulcer not present on prior assessment, feeding	2 900	see POC	

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2 900	Continued From page 17 tube, tracheostomy, suctioning, oxygen. The facility identified R23 on the annual MDS dated 6/19/17, same as MDS dated 4/4/17, and was identified with no pain. Document review of R23's Tissue Tolerance an assessment to evaluate pressure to areas that include bony prominence and prolonged pressure which could cause damage to tissue. See the following: 3/28/17-no redness throughout evaluation, is on a pressure reducing mattress, reposition every 2-2 ½ hours. 4/28/17-no redness throughout evaluation, remain on 2-2 ½ hour reposition schedule. 6/2/17- no redness noted, is on a pressure reducing mattress, reposition every 2 -2 ½ hours. Document review of facility Braden Scale Assessment for Predicting Pressure Sore Risk dated 4/28/17, and 6/2/17, revealed R23 was at high risk for developing pressure sore, skin very moist; chair fast-ability to walk severely limited or non-existent; mobility very limited-makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently; friction and shear are a problem-requires moderate to maximum assistance moving, complete lifting without sliding against sheets is impossible, frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance, spasticity, contractures or agitation leads to almost constant friction. Document review of facility Comprehensive Evaluation of Skin Inspection and Risk Factors dated 4/28/17, revealed R23 was at high risk for developing pressure sore; other risk factors	2 900		

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2 900	Continued From page 18 included head of bed elevated majority of the day, required assist with activities of daily living, had medical devices such as oxygen tubing; diagnosis if brain injury; had right ischium unstageable pressure ulcer measuring 2 centemeters (cm) by 1 cm by 0.1 cm depth. Analysis indicated R23 was at risk for developing pressure ulcer related to immobility, already existing pressure injury, assistance with all mobility and incontinence, pressure relieving mattress in place, remains on a turn and reposition every two hours. Document review of facility Comprehensive Evaluation of Skin Inspection and Risk Factors dated 6/2//17, revealed all areas same as 4/28/17 assessment, except the right gluteal fold unstageable pressure ulcer measured 4 cm by 1.5 cm by 0.05 cm depth. Analysis indicated R23 wound had worsened since hospital stay, is larger and deeper, continue to do dressing changes daily, turn and reposition every 2-2 ½ hours, up in wheelchair a couple times a day and requires two staff assist with turning and repositioning in wheelchair and with all mobility. Document review of R23's Care Area Assessment (CAA) dated 7/3/17, revealed triggered for pressure ulcer related to totally dependent with bed mobility, always incontinent of bowel and bladder, and had a pressure ulcer on right ischium unstageable. Required special mattress and wheelchair cushion. Review of R23's care plan print dated 7/26/17, revealed the following directions for staff: R23 currently had an unstageable area on right ischium (healed 4/7/17) and is at risk for more pressure ulcers. Interventions included: pressure relieving mattress on bed, treatments as ordered,	2 900		

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2 900	Continued From page 19	2 900		

notify physician/nurse practitioner if wound worsens, follow elimination care plan, turn and reposition every 2-2.5 hours assist of 2 staff, observe skin daily and weekly with bathing. Care plan problem of always incontinent of bowels and bladder. Interventions included: check incontinence product every 2 hours plus or minus 15 minutes and as needed, change as needed, provide protective skin care with each incontinence episode.

Document review of R23's Visual/Bedside Kardex Report (a Nursing Assistant [NA] assignment sheet) revealed NA directed to turn and reposition every 2-2.5 hours with two staff assist, R23 is unable to help at all, dependent on staff, off-load in wheelchair every 2-2.5 hours, incontinent of bowel and bladder, check incontinence product every 2 hours plus/minus 15 minutes, change as needed, provide protective skin care with each incontinence.

The following observations and interviews were dated 7/26/17 at 7:02 a.m. R23 was observed asleep in low bed, and fall mat on floor by bed. R23 was positioned slightly on the right side with a pillow at the back. R23 was positioned facing the doorway. At 7:18 a.m., licensed practical nurse (LPN)-B, entered R23's room, discontinued the tube feeding and started a nebulizer treatment. R23 remained in the same position slightly on the right side facing the door. At 7:27 a.m., same position as at 7:02 a.m.

During observations on 7/26/17, at 8:21 a.m., LPN-B entered R23's room, discontinued the nebulizer treatment. During interview at that time, LPN-B verified had not repositioned R23 at that time. R23 was observed positioned slightly on the right side with a pillow at the back. R23 was

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2 900	Continued From page 20	2 900		

positioned facing the doorway. At 8:30 a.m., same position, slightly on right side facing the door. At 8:45 a.m., same position, slightly on right side facing door with a pillow at the back. At 8:52 a.m., LPN-B entered R23's room, asked if R23 needed anything. LPN-B explained would get R23 up in a while. R23 remained positioned slightly on the right side, facing the door. At 8:58 a.m., nursing assistant (NA)-D entered R23's room. Observation at that time revealed R23 was positioned slightly on right side with a pillow to the back, facing the doorway. NA-D checked R23's incontinent brief and verified the brief and bed were wet. Observations at that time revealed the incontinent brief was heavily saturated. Observations at that time revealed NA-D provided R23 with a clean incontinent brief and clean bedding. No red areas were observed on the visible areas of right hip and back. NA-D stated R23 was to be repositioned every two hours. NA-D stated R23 had a wound on the right buttock. Observation at that time revealed one right wound dressing with hand written date of 7/26/17, 2:00 a.m. During interview at that time, NA-D verified R23 had a large urine incontinence. NA-D verified had not provided perineal care after incontinence. At 9:11 a.m., NA-D verified did not know when R23 had last been repositioned or checked for incontinence. At 9:12 a.m., NA-D and nursing assistant (NA)-A, positioned R23 on the left side, facing the window, with pillows at the back and between the legs. NA-D and NA-A verified R23 had a wound on the right buttocks. At 9:24 a.m., NA-A stated NA-G had completed R23's morning cares. They stated all residents cares are done between 7:00 a.m., and 8:00 a.m. At 9:39 a.m., NA-G stated had not completed morning cares for R23. NA-G stated R23's morning cares were completed by the night shift at 6:30 a.m., which included washing, dressing,

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2 900	Continued From page 21	2 900		

perineal care and repositioning. NA-G stated R23 was repositioned between 8:00 a.m., and 8:30 a.m., by LPN-B. At 9:45 a.m., LPN-B verified went to R23's room at 8:21 a.m., removed nebulizer treatment. LPN-B verified did not do any cares for R23 at that time. LPN-B and NA-A, stated the facility does not document repositioning for R23. LPN-B stated expected repositioning of R23 every two hours. LPN-B stated R23 would have been repositioned between 6:00 a.m. to 6:30 a.m., by the night shift. LPN-B verified the facility had no documentation of when R23 was repositioned. At 10:30 a.m., LPN-B stated expected perineal care with each incontinence. At 11:04 a.m., NA-A, NA-G and registered nurse (RN)-A, were observed to transfer R23 from wheel chair to bed with a mechanical lift, removed slacks, and positioned on left side facing the window while RN-A provided wound care to the right hip wound. Observations at that time revealed two foam dressings on the right hip located near each other. RN-A removed the smaller foam dressing to reveal a reddened area located on the right hip bone area. RN-A removed the larger foam dressing on the right hip to reveal one unstageable ulcer with a large amount of tan drainage on the dressing and foul odor. RN-A cleansed the wound with sterile water, applied medi-honey to the white eschar. The wound appeared approximately 3 centimeters with white eschar in the center, edges were dark pink in color. Review of the medi-honey pharmacy label with dispense date of 7/25/16, revealed to apply to wound every eight hours. RN-A covered both wounds with foam dressings. R23 was positioned on the left side facing the window with pillows to the back and between the legs. RN-A stated the right hip red area was new. RN-A stated she does wound care on Mondays and

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2 900	Continued From page 22 staff nurses complete wound care the rest of the week. RN-A verified medi-honey treatment started on 7/25/17. RN-A stated the facility had issues with faxing order to pharmacy and issues with pharmacy delivering the medi-honey. RN-A verified medi-honey had been ordered but not delivered for several days. RN-A stated physician had been notified of not starting the medi-honey when ordered. RN-A stated R23 was scheduled for debridement of the wound recently, was canceled due to issue with transportation and no nurse to go with R23 to the appointment. RN-A stated R23 was rescheduled for debridement on 7/31/17, at 1:00 p.m. RN-A described the wound as unstageable with eschar, outside eschar area is stage 4, and dressing soaked with tan drainage. RN-A stated the foam dressing could also have been soaked with urine due to the large incontinence. RN-A stated it was usual for R23 to have wound dressing soaked. RN-A stated she expected R23 to be repositioned every two hours, from back to left side and back to back again. RN-A stated she was aware R23 was positioned on the right side, same side as the right hip wound, and faced the doorway. RN-A stated the smaller red area on the right hip was probably from facing door for sometime, positioned on the right hip. RN-A stated the red area on right hip had appeared before and then goes away. RN-A stated she expected perineal care after each incontinence. RN-A verified the unstageable pressure ulcer had declined. On 7/27/17 at 12:01 p.m., director of nursing (DON) stated she expected R23 to be repositioned every 2-2 ½ hours according to the care plan. DON stated she expected R23 was not to be positioned on the right side open wound. DON stated she expected perineal care after each incontinence.	2 900		

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2 900	Continued From page 23 The following observations and interviews were dated 7/27/17 at 8:15 a.m. R23 was in bed on left side facing the window with a pillow to the back. During interview at that time, LPN-B stated R23 was just repositioned and LPN-B would do dressing change later. At 9:30 a.m., interview nursing assistant (NA)-H who stated R23 was to be repositioned every two hours and checked for incontinence every two hours. NA-H stated had cared for R23, who had a wound on the right hip (new fracture) and was not to be positioned on the right side. NA-H stated would provide pericare after each incontinence. At 9:35 a.m., interview nursing assistant (NA)-I stated R23 was to be repositioned every two hours and checked for incontinence every two hours. NA-I stated there is a kardex with instructions for care inside the closet door. NA-I stated had cared for R23, who had a wound on the right hip and was not to be positioned on the right side. NA-I stated would provide pericare after each incontinence. At 10:35 a.m., observations revealed NA-H positioned R23 to the left side while RN-A provided the dressing changes to the right ischium. RN-A removed the smaller foam dressing to right hip to reveal red area which measured 3 cm by 2 cm, blanchable and no drainage. RN-A applied a foam dressing to the red area. RN-A removed larger right hip dressing, saturated with tan drainage, wound measured 5.5 cm by 3.9 cm by 1.1 cm and 2 cm depth, with 75 percent eschar per RN-A. RN-A cleansed the wound with sterile water, applied medi-honey and covered the wound with a white absorbent dressing. RN-A and NA-H positioned R23 onto back with pillows between the legs. At 10:51 a.m., interview RN-A verified was aware R23 had previously been positioned on his right side, unstageable wound on the morning of	2 900		

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2 900	Continued From page 24 7/26/17. RN-A stated the night staff thought they were doing the right thing by placing R23 on the right side, off of left hip fracture. Reviewed Weekly Wound Documentation Forms with RN-A and during the review RN-A stated the facility Weekly Wound Documentation Forms dated 6/19/17 to 7/24/17, which identified one unstageable pressure ulcer on the right ischium. During interview at this time, RN-A verified the right ischium wound was found on 3/28/17, and was measured on 3/31/17, to be 1 cm by 1 cm, and unstageable. RN-A stated she expected tissue tolerance evaluation completed whenever a wound develops and with every return from the hospital. RN-A verified R23's care plan stated right ischium pressure ulcer healed 4/7/17 which was a different ulcer. RN-A verified R23's care plan was not revised to include the new ulcer found on 3/28/17. RN-A verified R23 was hospitalized from 4/23/17 to 4/28/17, with fecal impaction. RN-A verified the 5/4/17 physician progress note identified a left hip fracture, had a fall prior to hospitalization, and very difficult to determine if the fracture occurred at the nursing home. RN-A verified physician progress note dated 5/4/17, identified one- stage 2 decubitus right ischial ulceration, found prior to hospitalization, appears to be worse. RN-A verified R23's care plan for incontinence of bowel and bladder, directed protective skin care with each incontinent episode. RN-A stated protective skin care was the use of barrier cream after each incontinence. RN-A stated the care plan lacked direction to provide perineal care after incontinence because perineal care is a standard order of care, staff were expected to provide with each incontinence. RN-A verified the facility had no way to identify when R23 was repositioned and checked for incontinence. RN-A stated R23	2 900		

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may be dry all night and then have a large incontinence. RN-A verified physician order dated 7/14/17, to reposition every two hours, and verified the care plan directed reposition every 2-21/2 hours. RN-A verified physician order dated 7/17/17, for medi-honey to the wound, and verified the treatment did not start until 7/25/17 when the ointment arrived, a period of eight days after the order. RN-A stated staff made attempts to obtain medi-honey. RN-A verified physician progress note dated 7/25/17, in which the physician identified R23's prior debridement was canceled and physician ordered right hip x-ray. RN-A stated the debridement was canceled due to not having the right transportation, procedure had been rescheduled a week later and canceled due to no staff available to go with R23. RN-A stated the right hip x-ray was completed on 7/25/17, at 1:00 p.m., and debridement was scheduled for 7/31/17, at 1:00 p.m. RN-A verified physician progress note 4/11/17, identified visit was for a fall and head laceration overnight and unstageable pressure ulcer found on 3/28/17. RN-A verified Weekly Wound Documentation Form dated 4/7/17 and progress note dated 4/13/17, identified right ischial wound healed. RN-A verified R23 sustained a fall from bed on 4/11/17, with a head laceration and was seen by the physician on 4/11/17. RN-A verified R23 was hospitalized 4/23/17 to 4/28/17, for evaluation of the left hip fracture.
RN-A verified significant change progress note dated 4/23/17, which identified a large red area approximately 5 cm by 3 cm and inside the red area was an open area measured 3 cm by 1 cm on right buttock upper thigh crease. RN-A stated R23 was sent to the hospital on 4/23/17, for evaluation of left hip fracture. RN-A verified R23 developed right ischial ulcer on 3/28/17, healed on 4/7/17, developed again on 4/23/17,

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2 900	Continued From page 26 measuring 5 cm by 3 cm and 3 cm by 1 cm open, hospitalized on 4/23/17, and returned 4/28/17 with wound worsened. Document review of facility Weekly Wound Documentation Form revealed the following: 3/31/17-pressure (ulcer) right ischium 1 centimeter (cm) by 1 cm, unstageable, no drainage, no odor. analysis-wound unchanged, continue current plan. treatment-repositioning and barrier cream. 4/7/17-pressure right ischium, 0 cm by 0 cm, unstageable,no odor, improved. analysis- wound is healed. treatment-repositioning and barrier cream. 5/5/17- pressure right ischium, 2 cm by 1 cm by 0.1 cm depth, unstageable, no drainage, no odor, improved. analysis-on bedrest related to hip fracture, pressure reducing mattress in place, cover with foam daily. 5/11/17-pressure right ischium, 2 cm by 0.8 cm by 0.1 cm depth, unstageable, no drainage, no odor, improved. analysis- on bedrest related to hip fracture, pressure reducing mattress in place, cover with foam daily. 5/19/17-pressure right ischium, 3 cm by 0.5 cm, by 0.1 cm depth, unstageable, no odor, no drainage, stable. analysis-turn and reposition every 2 -2.5 hours. cover with foam daily. 6/12/17-pressure right ischium, 2.8 cm by 0.5 cm by 0.1 cm depth, unstageable, no drainage, no odor, improved, analysis-remains on 2-2.5 hour reposition, wound remains same. Cleanse with wound wash, santyl (a collagenase ointment used as an enzymatic debriding ointment) to eschar,	2 900		

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2 900	Continued From page 27 cover with foam dressing, change daily. 6/19/17-pressure right ischium, 3 cm by 4 cm by 0.5 cm depth, pressure, unstageable, no drainage, no odor, progress is no change, analysis-remains same size, turn and reposition every 2-2.5 hours, cleanse with wound wash, santyl to eschar, cover with foam dressing, change daily. 6/28/17-pressure right ischium, 3.6 cm by 2.8 cm by 0.5 cm depth, stage 3, moderate serosanguinous drainage, no odor, progress-no change, analysis-remains same size, reposition every 2-2.5 hours. cleanse with wound wash, santyl to eschar, cover with foam dressing, change daily. 7/4/17-pressure right ischium, 4.7 cm by 3.1 cm, no depth identified, unstageable, scant and moderate drainage, serosanguinous and green drainage odor-yes, cleanse with wound wash, santyl to eschar, cover with foam dressing, change daily. analysis- augmentin (antibiotic) two times a day, continue with current dressing change, remains on reposition every 2-2.5 hours. 7/17/17-pressure right ischium, 5 cm by 3 cm by 1.3 cm depth, unstageable, scant drainage, serosanguinous, no odor, cleanse with wound wash, santyl to eschar, cover with foam dressing, change daily, progress-declined, analysis- no longer has green drainage, eschar is loosening and depth is able to be measured, remains on reposition every 2-2.5 hours, refer to physician for surgical/mechanical	2 900		

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debridement for left ischium
unstageable pressure ulcer.
7/24/17-pressure right ischium, 5 cm by 3.5 cm by 2 cm depth stage 4, heavy
drainage, tan color, no odor, right ischial wound care-cleanse with
wound wash, apply medi-honey to eschar/slough, cover with foam
dressing, change every 8 hours, analysis-continue current treatment of
medi-honey, has appointment on 7/31/17 for debridement of wound.

Document review of facility progress notes revealed the following:
On 4/23/17 R23 on rounds at 12:00 a.m. had large red area approximately 5 cm by 3 cm, inside red area is open area 3 cm by 1 cm, on right buttock upper thigh crease.

On 6/2/17-returned from hospital about 1 p.m. today, continues to have trachea in, wound on right gluteal fold measures 4 cm by 1.5 cm and 0.5 cm in depth, had worsened since left the facility. Also indicated on 6/2/17, R23 was lying on right side in bed at 40 degrees angle.

On 7/19/17 upon cares at 8:30 a.m., R23 appeared to have no foam dressing over right hip wound, this has happened multiple times in last week, also laying on right side and not on the left side. The note stated brief lines exactly on top of wound, complete bed change and put pad under R23 so brief would not irritate the wound. The note indicated a new mark above the wound that measured 5.3 cm by 3.5 cm.

On 7/22/17 a red area on right hip measured 2.5 cm by 3 cm and blanchable.

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2 900	Continued From page 29 Document review of progress notes related to lack of medi-honey that was ordered on 7/17/17 indicated that on 7/19/17, 7/20/17, and 7/25/17, staff called the facility pharmacy to obtain medi-honey. Document review of the right hip x-ray dated 7/25/17, revealed degenerative joint disease of right hip and no evidence to indicate osteomyelitis at this time. Document review of physician orders revealed the following orders with start date: On 7/14/17-reposition every 2 hours. On 7/17/17-right ischial wound care, clean with wound wash, apply medi-honey to eschar/slough, cover with foam dressing, change every 8 hours. On 7/25/17-X-ray right hip (evaluate for possible osteomyelitis). Document review of physician/nurse practitioner progress notes revealed the following: On 3/14/17-skin warm and dry, no suspicious lesions or wounds. On 4/11/17- sustained a fall overnight and unstageable pressure ulcer was found 3/28/17, on ischium. On 5/4/17-was hospitalized 4/23/17 to 4/28/17 for fecal impaction. Diagnosis included right hip fracture diagnosed incidentally during hospitalization, did have a fall prior to hospitalization. Diagnosis also indicated a stage two decubitus right ischial ulceration found prior to hospitalization, appears to be worse. On 6/5/17-during assessment visit, the sacral wound was found to have no dressing in place. Skin warm and dry, has right ischial tuberosity that is non-stageable, approximately 4 cm by 1.5 cm covered with black eschar and approximately 0.5 erythema around the perimeter, no drainage,	2 900		

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no induration. The note indicated R23 was in the emergency room over the week-end for elevated temperature, constipation and chest x-ray revealed infiltrates and started on antibiotics.
On 6/9/17-impression is pneumonia.
On 7/14/17-ordered to reposition every 2 hours to prevent excessive pressure to the area. R23 has been referred to general surgery, had an appointment previously but was discontinued due to lack of staff at the facility to accompany to the appointment. Will reschedule this for a very needed debridement.
On 7/25/17- revealed R23 was seen for acute visit for follow up of right ischial pressure ulcer. R23 was last seen on 7/14/17. R23 had a scheduled appointment with surgery on 7/7/17, for debridement of pressure ulcer. Physician was told by healthcare coordinator today that this appointment was canceled due to no nursing staff available to accompanying R23. Physician was told no follow-up appointment had been made. Nursing reports ulceration is malodorous, increased drainage, possible pain, pain medication given with good effect. Right ischial pressure ulceration was examined, wound bed appears to be necrotic and larger than last exam. R23 had significant grimacing when physician palpated the edges of wound. Wound was malodorous. There is a 2 cm red area on right hip that is blanchable. Medi-honey was ordered after last provider visit, which physician was told, had not yet been started . There is also a new area on right hip, which per nursing notes on 7/22/17, showed a 2.5 cm red area which is blanchable. A foam has been applied to this area. Physician assessment and plan-unstageable right ischial ulceration. Will do a right hip X-ray to assess for possible osteomyelitis, will consider doing CT scan due to contractures, ordered blood work, previous wound culture was polymicrobial and

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was on augmentin (antibiotic) for 10 days. Physician spoke to nursing about medi-honey as it is currently not available. Nursing said it was coming in today at 2 p.m. Physician asked for appointment for debridement as this was canceled without physician knowing. Physician told the facility this is medically necessary and should not be postponed.

Document review of hospital Consultation report dated 4/23/17, revealed reason for exam was abdominal pain and fever. Also noted right buttocks stage 1 decubitus ulcer, no erythema, induration, drainage, bleeding or warmth, mepilex border reapplied.

Document review of nursing progress notes revealed the following:
On 4/11/17-unstageable pressure ulcer found on ischium on 3/28/17.
On 4/23/17-has large red area approximate 5 cm by 3 cm inside red area is open area 3 cm by 1 cm on right buttock upper thigh crease, area cleansed and foam dressing applied, positioned to off- load pressure in the area.
On 7/23/17-nursing progress note identified orders-right ischial wound, clean with wound wash, apply medihoney to eschar/slough, cover with foam dressing, change every 8 hours.

During interview on 7/25/17 at 9:33 a.m., R23's medical doctor (MD)-A stated R23 had a new unstageable pressure ulcer which started in the facility. MD-A stated on three occasions found no dressing on the wound and have found R23 positioned on the unstageable wound. MD-A stated not aware the debridement appointment was canceled because no staff were available to go with R23 to the appointment. MD-A stated had changed the wound treatment recently to

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2 900	Continued From page 32 medi-honey and was not aware that the facility had not obtained the ointment timely. During interview on 7/26/17, at 12:01 p.m., director of nursing (DON) stated she expected R23 to be repositioned every 2-2 1/2 hours according to the care plan. DON stated she expected R23 was not to be positioned on the right side open wound. DON stated she expected perineal care after each incontinence. R70's Minimum Data Set (MDS) dated 5/11/17, indicated R70 had no cognitive impairment, required assistance of two persons for bed mobility and had a diagnosis of quadriplegia. The MDS further indicated R70 had one stage III pressure ulcer and was at risk of developing a pressure ulcer. The MDS also indicated R70 had a pressure reducing device for his chair and bed, received pressure ulcer care and applications of ointments/medications. R70's Visual/Bedside Kardex Report printed on 7/27/17, indicated he was to be assisted with turning and repositioning every 2 hours-2.5 hours with an assist of two staff members and off load when in his wheel chair every 2 hours. The report further indicated R70 was to have a heel elevating cushion to keep heels off the bed all the time, and to be checked for incontinence every 2 hours. R70's Treatment Administration Record (TAR) dated 1/16/16, indicated that every shift the nurse was to ensure that staff were following care plan for turning, repositioning and documentation. A Turn and Reposition and Offloading Per Care Plan Task Sheet for R70 did not have check marks for every shift on 14 days between 6/27/17, and 7/25/17. A Tissue Tolerance (TT) was conducted on 7/14/17, with plan for R70 to remain on a 2-2.5 hours turn and reposition schedule.	2 900		

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2 900	Continued From page 33 Skin Assessment progress notes from 4/7/17, through 7/26/17, revealed the following: 4/17/17, left lateral heel measurement only: length, 1 centimeter (cm) x width 1 cm x unstageable depth. 5/11/17, left lateral heel measurement only: 1.5 x 1.2 x stage III. 6/12/17, left lateral foot measurements: anterior: 0.4 x 0.2 x unstageable and posterior 1 x 1.02 x unstageable. 7/24/17, left lateral foot measurements: anterior 0.5 x 0.5 x unstageable and posterior 0.25 x 0.25 unstageable. 7/26/17, right heel scar tissue 1.5 x 1.0 and coccyx: 4.5 x 4 x stage II. During continuous observation on 7/26/17, from 7:05 a.m. to 10:24 a.m. (3 hours and 19 minutes) R70 was observed laying in his bed on his back without being repositioned (off loaded) or checked for incontinence. At 10:24 a.m. writer queried two staff members in hallway, Registered Nurse (RN)-A and RN-B, and voiced concern regarding repositioning of resident. Resident was subsequently repositioned and his right heel was raised off of the bed. On 7/26/17, at 10:40 a.m. during an interview, RN-A confirmed R70 had not been turned or repositioned since 7:05 a.m. and his right heel had been resting on the bed. RN-A and RN-B confirmed there was a quarter sized darkened area on R70's right heel and his skin over the coccyx area had a half dollar sized pink/white area. RN-A stated R70 should be checked on, turned and repositioned every 2 hours and his heels should have been elevated off of the bed. On 7/26/17, at 11:05 a.m. during an interview with R70 he stated he is not turned and repositioned for over 3 hours every shift and when that	2 900		

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2 900	Continued From page 34 happens I get stiff and worry about my skin opening up. On 7/26/17, at 12:39 p.m. during an interview with Nursing Assistant (NA)-A confirmed R70 should be turned and repositioned every two hours. On 7/27/17, at 7:56 a.m. during an interview, DON stated her expectations for turning and repositioning residents would be based on assessments and reflected in the resident's care plan. On 7/27/17, at 8:24 a.m. during an interview, RN-A stated she had reviewed R70's wounds and he had a new pressure ulcer to his coccyx area that was not present one week ago and his right heel has an area of scar discoloration which she will monitor to see if it is a pressure ulcer or old scar tissue. RN-A further indicated that turning and repositioning of R70 needs to be done every two hours or wounds could develop. On 7/27/17, at 1:53 p.m. during an interview, RN-A stated documentation by NAs had multiple missing check marks under R-70's turning and repositioning log between 6/27/17, and 7/25/17, so it was not known if R70 was repositioned or not on those shifts. The facility Prevention of Pressure Ulcers Policy and Procedures dated 2/2014, General Preventive Measures for a Person in Bed directed staff to change resident's position at least every two hours or more frequently if needed. Pressure Ulcer stages defined by the National Pressure Ulcer Advisory Panel (NPUAP): Stage 1: Nonblanchable Erythema: Intact skin	2 900		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 35 with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage 2: Partial Thickness Skin Loss: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. Stage 3 Pressure Ulcer: Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough (yellow devitalized tissue, that can be stringy or thick and adherent on the tissue bed) and/or eschar (dark, dead tissue) may be visible. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Ulcer. Stage 4 Pressure Ulcer: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling oftenoccur. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Ulcer. Unstageable Pressure Ulcer: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed	2 900		

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2 900	Continued From page 36 because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration. Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Policies provided by facility: Prevention of Pressure Ulcers dated 2/2014: General Guidelines: Indicated pressure ulcers are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area and subsequent destruction of tissue. The most common site of a pressure ulcer is where the bone is near the surface of the body. pressure ulcers are often made worse by continual pressure, heat, moisture, irritating substances on resident's skin (i.e., perspiration, feces, urine, wound discharge, soap residue, etc) decline in nutrition and hydration status, acute illness and/or decline in resident's physical and / or mental condition. Interventions and Preventive Measures-indicated change position at least every 2 hours or more frequently if needed. Place resident on a minimum of a 2 hour check and change program.	2 900		

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2 900	Continued From page 37 Risk Factor-Bowel and Bladder Incontinence-check for incontinence at least every 2 hours and clean skin when soiled. Perineal Care policy dated 10/2015: For male indicated-if stool present use perineal wipes, wet wash cloth and apply skin cleansing spray or use perineal wipes, wash starting with urethra and work outward, retract foreskin, wash penis, scrotum, inner thighs, gently pat dry. reposition and wash rectal area. Skin Program policy dated 9/2016: Indicated to ensure a resident who enters the facility without pressure ulcers does not develop pressure ulcers unless the individuals clinical condition demonstrates that they were unavoidable. on admission, baseline assessment of skin status done within 2 hours of admission. further comprehensive skin assessments will be done with readmission, annually, and change of condition or surface comprehensive wound assessment will be completed when a skin ulcer is identified. SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise policies and procedures for pressure ulcers. The director of nursing could educate all staff on skin care. The director of nursing could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development.	2 900		

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2 900	Continued From page 38 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide necessary cares/services to prevent urinary tract infections (UTI) for 2 of 2 residents (R64, R125) reviewed for urinary catheter. Findings include: R64 was admitted to the facility 8/18/15 according to the admission sheet. Review of the medical record indicate R64 to have current diagnoses of urinary obstruction, urinary retention (inability to completely empty the bladder), hydrocele (an	2 910	see POC	8/31/17

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2 910	Continued From page 39	2 910		

accumulation of fluid around the testicles), phimosis (an inability to retract the foreskin over the penis) and a urinary tract infection (UTI).

During an observation on 7/26/17, at 7:15 a.m. R64 was in bed with the catheter bag cover unsnapped and the lower quarter of the catheter bag uncovered and in direct contact with the floor. At 8:12 a.m. nursing assistant (NA)-J entered the room to assist with morning care and did not provide pericare or catheter care during the partial bath. NA-J assisted R64 to wheelchair while holding catheter bag above resident bladder.

When interviewed, NA-J stated she had received no training at the facility related to the provision of catheter care and it was briefly taught during her nursing assistant course the previous fall. NA-J was unaware of the need to keep catheter bag below the bladder level to prevent urine from reentering into the bladder. NA-J unable to recall any training in catheter cleaning instruction.

During an interview on 7/26/17, at 1:57 p.m. with licensed practical nurse (LPN)-A, she was unable to find providing catheter care on the treatment sheet for R64 and unable to state if it was being provided.

An interview with registered nurse (RN)-A on 7/28/17, at 8:34 a.m. revealed that NAs have access to the plan of care and that providing catheter care is delegated to the NAs and the nurse is responsible to see that it is done.

Document review for R64 including a note from urology dated 1/17/17, directed staff to "please complete pericare for pt [patient/R64]!" A note from the medical doctor, indicated on 7/20/17,

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2 910	Continued From page 40	2 910		

resident had become more somnolent and less interactive. The current care plan included instruction to keep catheter bag below the bladder but no direction related to providing catheter care.
R125's Minimum Data Set (MDS) dated 5/4/17, indicated R125 had moderate cognitive impairment, a diagnosis of malignant bladder cancer and an indwelling Foley catheter.

Care Plan dated 5/4/17, identified R125 needed assistance with urinary function related to R125 having an indwelling Foley catheter.

Medical doctor (MD) progress note dated 6/16/17, identified R125 had Alzheimer's dementia. This is severe, and he is unable to make his own medical decisions.

Medical Doctor Orders identified R125 was on antibiotics for a UTI from 5/13 -5/23/17, and another UTI from 5/31/17 - 6/7/17.

Observation on 7/24/17, at 3:30 p.m., R125 was lying in bed sleeping with the Foley catheter tubing running down his left leg and the catheter bag was in a blue cloth bag lying directly on the floor in front of the bed.

On 7/25/17, at 10:19 a.m., R125 was sitting in his wheelchair in his room with the catheter bag lying on the floor as R125 was trying to wheel self forward and was running over the catheter tubing with the wheel chair tire.

On 7/26/17, at 8:39 a.m., R125 observed to be sleeping in bed with wheelchair parked in front of the bed and catheter bag still connected to left side of wheelchairs arm rest.

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2 910	Continued From page 41 On 7/27/17, at 7:10 a.m., R125 observed wheeling self in wheelchair down the hall towards the common area. R125's catheter bag was hanging off the left side of his armrest of his wheelchair. Dark yellow urine is noted to be pooled in the bottom of the catheter tubing that is dragging on the floor. Interview on 7/27/17, at 7:59 a.m., nursing assistant (NA)-E stated that R125 always puts his catheter bag on the left side of his arm rest on his wheelchair because he transfers himself. NA-E further stated she did not realize that urine could backflow into R125's bladder if the catheter bag was not positioned below the bladder level and therefore putting R125 at a higher risk to develop a UTI. On 7/27/17, at 8:12 a.m., R125 observed to be wheeling self to dining room with his catheter bag hanging off the wheelchairs left arm rest and urinary tubing was coiled and dragging on the floor, R125 was running over his own tubing until this surveyor notified RN-D of the event. During this time RN-D stated that R125's urine is unable to drain with his catheter bag hanging off the left side of his arm rest on his wheelchair. RN-D further stated, "I don't know what the answer is ...I just want to get him up to the table so he can eat." During interview on 7/27/17, at 8:53 a.m., director of nursing (DON) verified her expectation would be to have the resident's catheter bag to be hanging below the bladder to allow proper drainage of urine and to help prevent a UTI. A policy, "Urinary Catheter Care," dated 2010, revised November 2016, indicates to check the resident frequently to be sure he is not lying on	2 910		

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2 910	Continued From page 42 the catheter and to keep the catheter and tubing free of kinks. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. Infection Control identifies, be sure the catheter tubing and drainage bag are kept off the floor. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents with an indwelling Foley catheter to assure they are receiving the necessary treatment/services to prevent urinary tract infections and to restore as much normal bladder function as possible. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide assistance with shaving as directed by the care plan for 1 of 4	2 920	see POC	8/31/17

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2 920	Continued From page 43 residents (R62) and failed to provide incontinence services/cares for 1 of 4 residents (R23) for both residents who were reviewed for activities of daily living (ADL). Findings include: R62's Quarterly Minimum Data Set (MDS) dated 5/2/17, identified R62 with severe cognitive impairment and required extensive assist of 1 with personal hygiene. R62's care plan dated 6/25/15, identified R63 with an intervention of assistance with shaving or plucking facial hairs upon discovery. R62's kardex (nursing assistant assignment for resident cares) dated 7/27/17, identified R63's grooming needs assist with shaving or pluck facial hair upon discovery per R63's wishes. During observation on 7/24/17, at 4:07 p.m., R63 was sitting on the couch in the common area during a scheduled singing activity and R63 was noted to have several long unshaven chin hairs. During subsequent observations on 7/25/17, at 9:35 a.m., 7/26/17, at 12:53 a.m., and on 7/27/17, at 7:39 a.m., R63 continued to have long, unshaven, chin hairs. During interview on 7/26/17, at 1:52 p.m., nursing assistant (NA)-B verified that R63 should have been shaved. Further stated R63 does not have her own personal shaver to be shaved. When interviewed on 7/26/17, at 1:57 p.m., NA-C verifies that R63 needs 1 assist to help with shaving per the care plan and that R63 should have had her chin hairs shaved.	2 920		

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2 920	Continued From page 44 During interview on 7/27/17, at 7:48 a.m., registered nurse (RN)-D verified that R63 should have had her chin hairs shaved and stated, "This is my worst fear living in a nursing home and to have all those facial hairs." Interview on 7/27/17, at 8:51 a.m., director of nursing (DON) verified her expectation is to shave each resident as needed and to follow the care plan as directed. DON further stated they would contact social services to get R63 a personal shaver. R23 was admitted to the facility on 7/14/16, according to facility Admission Record. R23 had diagnosis that included acute respiratory failure with hypoxia, traumatic brain injury, neurogenic bowel, neuromuscular dysfunction of bladder and seizures, according to facility physician progress note dated 7/25/17. Facility identified R23 on the quarterly Minimum Data Set (MDS), 4/4/17, to have short and long term memory problem, severely impaired decision making, totally dependent on two staff for activities of daily living which included bed mobility, transfers, dressing, toileting and hygiene, always incontinent of bowel and bladder, pain unable to answer, functional limitation in range of motion on both sides, unstageable pressure ulcer due to slough or eschar, pressure ulcer not present on prior assessment, feeding tube, tracheostomy, suctioning, oxygen. The facility identified R23 on the annual MDS dated 6/19/17, same as 4/4/17 MDS, and was identified with no pain. Document review of R23's Bladder and Bowel	2 920		

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2 920	Continued From page 45 Assessment dated 6/19/17, identified risk factors included impaired mobility and dependent on two staff for transfers, currently incontinent of bladder, clothes and incontinent product is wet. Analysis indicated incontinent of bowel and bladder, has diagnosis of neurogenic bladder and staff assist R23 with all toileting needs. Review of R23's care plan print dated 7/26/17, included the following directions for staff: Care plan problem of always incontinent of bowels and bladder. Interventions included: check incontinence product every 2 hours plus or minus 15 minutes and as needed, change as needed, provide protective skin care with each incontinence episode. Document review of R23's Visual/Bedside Kardex Report (NA assignment sheet) revealed NA directed to turn and reposition every 2-2.5 hours with two staff assist, R23 is unable to help at all, dependent on staff, off-load in wheelchair every 2-2.5 hours, incontinent of bowel and bladder, check incontinence product every 2 hours plus/minus 15 minutes, change as needed, provide protective skin care with each incontinence. During observations on 7/26/17, at 8:58 a.m., nursing assistant (NA)-D entered R23's room. Observation at that time revealed R23 was positioned slightly on right side with a pillow to the back, facing the doorway. NA-D checked R23's incontinent brief and verified the brief and bed were wet. Observations at that time revealed the incontinent brief was heavily saturated. Observations at that time revealed NA-D provided R23 with a clean incontinent brief and clean bedding. However, no perineal care was completed before the new incontinent brief was	2 920		

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2 920	Continued From page 46 put on the resident. NA-D verified had not provided perineal care after incontinence. 10:30 a.m., licensed practical nurse-B stated perineal care should be done after every incontinence episode. RN-A verified R23's care plan for incontinence of bowel and bladder, directed protective skin care with each incontinent episode. RN-A stated protective skin care was the use of barrier cream after each incontinence. RN-A said staff were expected to provide perineal cares with each incontinence episode. During interview on 7/26/17, at 12:01 p.m., director of nursing (DON) stated she expected perineal care provided after each incontinence. Perineal Care policy dated 10/2015 included, for male indicated-if stool present use perineal wipes, wet wash cloth and apply skin cleansing spray or use perineal wipes, wash starting with urethra and work outward, retract foreskin, wash penis, scrotum, inner thighs, gently pat dry, reposition and wash rectal area. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all employees responsible for providing direct cares for residents the need to follow the residents comprehensive care plan. Also to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program	21375		8/31/17

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21375	Continued From page 47 Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene procedures were followed by staff for 1 of 1 resident (R64) observed receiving morning care to prevent the spread of infection. Findings include: R64 had been observed on 7/26/17, at 8:39 a.m. when nursing assistant (NA)-J failed to wash her hands after providing morning cares which included using wipes as R64 had been incontinent of stool. NA-J disposed R64's soiled brief in a plastic bag. NA-J removed her gloves and left R64's room, taking the bag containing the soiled brief. NA-J had not washed her hands following cares for R64 and immediately at 8:40 a.m. NA-J was observed going into another resident's room approached the bedside, uncovered resident and asked the resident if she would like to get up for breakfast. NA-J donned gloves in the room, then stated "let me get the lift." NA-J left the resident's room and retrieved the standing lift. When NA-J returned to the resident's room, she was asked about handwashing. NA-J verified she had not washed her hands after removing gloves and doing peri care for R64. NA-J stated I usually go out to the nursing desk after cares and wash hands, but just got nervous today.	21375	see POC	

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21375	Continued From page 48 According to the facility policy dated 10/14 entitled Handwashing/Hygiene, employees must wash their hands for at least twenty (20) seconds before and after assisting a resident with personal care and after handling soiled or used linens. SUGGESTED METHOD OF CORRECTION: The director of nursing could give education to all staff responsible for preventing infection. Also to monitor for ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		8/31/17

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	00149	A. BUILDING: _____ B. WING _____	07/28/2017

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21426	Continued From page 49 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 6 newly hired employees (E-A, E-F), within the past four months had evidence of tuberculosis screening and tuberculosis skin tests (TST); failed to ensure 1 of 6 newly hired employees (E-D) within the past four months had TST results interpretation; failed to ensure 2 of 5 residents (R92, R42) had evidence of tuberculosis screening on admission; and failed to ensure 4 of 4 residents (R95, R84, R107, R42) received first and/or second step TST. Findings include: HEALTHCARE WORKERS: Document review on 7/25/17, of facility Baseline Tuberculin Skin Testing (TST) and Screen for Healthcare Workers (HCWs), facility new hires and first day working information, revealed the following information: SCREENING AND TST: E-A had hire date of 5/16/17. First day working with residents was 5/24/17. Screening for symptoms was completed but not dated. First step TST was administered on 7/25/17, date of review of document. A hand written note on the TST form was dated 7/25/17, and stated lost original sheet. E-F had hire date of 7/10/17. First day working with residents was 7/18/17. The facility had no evidence that E-F had symptom screen and first step TST. INTERPRETATION:	21426	see POC	

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21426	Continued From page 50	21426		

E-D had hire date of 5/12/17. First step TST was administered 5/12/17, read on 5/14/17, with results of negative and 0 millimeters (mm). Second step TST was administered on 5/24/17, read on 5/26/17, with results of 0 mm. There was no indication of the interpretation of the reading as positive or negative.

RESIDENTS:
R42 was admitted to the facility on 5/26/17. There was no evidence of symptom screening.

TUBERCULIN SKIN TESTS (TST):
R92 was admitted to the facility on 7/28/16. R92 was given first step TST on 7/30/16, with results of negative and 0 mm. There was no evidence of date the first step was read. R92 was given second step TST on 8/3/16, with results of negative and 0 mm. There was no evidence of date the second step was read.

R95 was admitted to the facility on 10/13/16. There was no evidence that R95 received first step TST. R95 was given second step TST on 10/27/16, with results of negative. There was no evidence of date the second step was read and no evidence of mm of induration.

R84 was admitted to the facility on 2/22/16. There was no evidence that R84 received first step TST. Second step TST was given on 3/7/16. There was no evidence of date the second step was read and no evidence of mm of induration and interpretation of positive or negative.

R107 was admitted to the facility on 3/7/17. There was no evidence that R107 received first step TST. R107 was given second step TST on 3/21/17, with results of negative and 0 mm. There was no evidence of date the second step

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21426	Continued From page 51 was read. R42 was admitted to the facility on 5/26/17. There was no evidence of first and second step TST. Document review of facility Tuberculosis Prevention and Control Program dated 7/2014, revealed the following: Page 4-Resident Tuberculosis Program: 1. A resident's clinical record must contain a report of a tuberculin test within three months prior to admission or within 72 hours after admission. F the first step TST is negative, a second step will be completed one week to three weeks after the first test is read. Risks/History and Symptoms screen must also be completed. Page 6-Tuberculosis Control Plan for Health Care Workers: 1. All healthcare workers and volunteers of the facility will be tested prior to employment or volunteering. 2. All tests must also include risk/history and symptoms screen. During interview on 7/28/17, at 8:15 a.m., director of nursing (DON) verified although symptom screening are not dated, they are completed at time of first step TST. DON verified the lack of interpretation of negative or positive for E-D. During interview on 7/28/17, at 11:20 a.m., DON verified facility had no further evidence of residents screening and TST. SUGGESTED METHOD OF CORRECTION: The director of nursing could review/revise	21426		

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21426	Continued From page 52 policies and procedures for resident and employee Tuberculosis screening and perform audits to ensure the policy was being followed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an environment that was clean, sanitary and in good repair for 5 of 89 resident rooms, 1 of 1 resident (R86) rooms with leaking bathroom ceiling and hallways, tub rooms, dining room and family lounge. Also for 1 of 1 resident (R2) with a wheelchair in need of repair. Findings include: The following rooms and concerns were observed during a tour with the administrator on 7/28/17, at 8:30 a.m. 2E8-2- bathroom ceiling tile with large brown stains. 2E20-2-closet door off the tracks and leaned against the wall. 2E44-2-TV cable hanging down near the	21665	see POC	8/31/17

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21665	Continued From page 53 doorway. 3W61-During observations of R86's room on 7/26/17, at 10:50 a.m., a live ant and dead green long tailed flying bugs called midges, were observed on the counter between two closets, dead ant on bathroom sink, live ant on bathroom floor, many dead gnats and dead midges on bedside stand and on the window sill. Observations during the environment tour with the Administrator on 7/28/17, at 8:30 a.m., revealed dead gnats (small flying bug) on bedside stand, large area of hard plastic on bathroom ceiling instead of ceiling tile, with approximately 3 inches wide area the length of the plastic that exposed pipes above the ceiling. During interview at that time, Administrator stated the facility has a roof leak, the hose is draining water from the roof into the wastebasket (which is located next to the toilet). Administrator verified ceiling pipes were visible. Administrator verified bugs on the bedside stand. Administrator stated pest control was at the facility every 30 days. Document review of facility Grievance/Concern Report Form dated 3/15/17, revealed hand written concern of leak in R86's bathroom ceiling. A temporary fix was put into place several weeks ago which included a pipe draining into a bucket. No further action had been taken by the facility. This concern was brought up by the Ombudsman. Action taken was offered to move R86 to another room, R86 refused to move. 3w68-2-3 bathroom tile with brown stains, tape covering door latch. 3w80-1-bathroom ceiling tile with brown stains. 200 wing east tub room-missing ceiling tile.	21665		

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21665	Continued From page 54 200 west wing carpet stained and loose in areas. 300 wing hallway carpets stained. 300 wing family lounge peeling plaster, brown ceiling stains. 300 wing dining room doorway with peeling plaster, brown stains on ceiling above doorway. 300 north wing-free standing fan on 300 north hall thick dust. Although a policy was requested, none was provided that addressed maintenance of the building. During interview at the time of the tour on 7/28/17, at 8:30 a.m., Administrator verified the areas of concern. He stated nurses use the computer system to notify maintenance director of needed repairs. Maintenance director checks this every day. Facility has quality council meeting every morning and afternoon where department heads report on their assigned rounds room checks. R2's wheelchair had been observed on 7/26/17 at 12:29 p.m. the right wheelchair arm on R2's wheelchair were noted to be torn and cracked, with exposure to the metal frame as well as one of the foot straps were broken off and hanging down towards the floor. R2 had been asked if the facility offered to fix the arm of the wheelchair. R2 stated, "Nope!" R2 care plan reads, "I do use a wheelchair for mobility." The intervention is for staff to monitor for unpleasant odors and clean/replace wheelchair cushions/covers/equipment when needed. During an interview on 7/27/17 at 11:31 a.m. with registered nurse (RN)-A stated when things need	21665		

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21665	Continued From page 55 to be fixed or replaced staff are to update the maintenance department on their computer program called "TELL." Interview on 7/27/17 at 12:54 p.m. with director of nursing (DON) stated the facility cannot fix R2 wheelchair because hers is custom and if they attempt can void the warranty of the manufacturer. R2 is placed in her custom wheelchair on a daily basis. DON stated her expectation of staff would have reported the damage to the wheelchair maker before now. Interview with DON on 7/27/17 at 2:19 p.m. in which the DON supplied the surveyors with daily audits completed for each room including resident equipment. DON reviewed the audits and verified there was no documentation, which would have identified R2 damage to the wheelchair. Interview with administrator on 7/28/17 at 9:38 a.m. stated each wing is gone through daily to identify areas that need addressed. Administrator stated the wheel chair should been identified during unit manager daily rounds. Policy regarding the maintenance of resident equipment was requested, but not supplied. SUGGESTED METHOD OF CORRECTION: The administrator and/or maintenance director could monitor equipment and the physical plant for needed repair, cleaning and sanitizing. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		